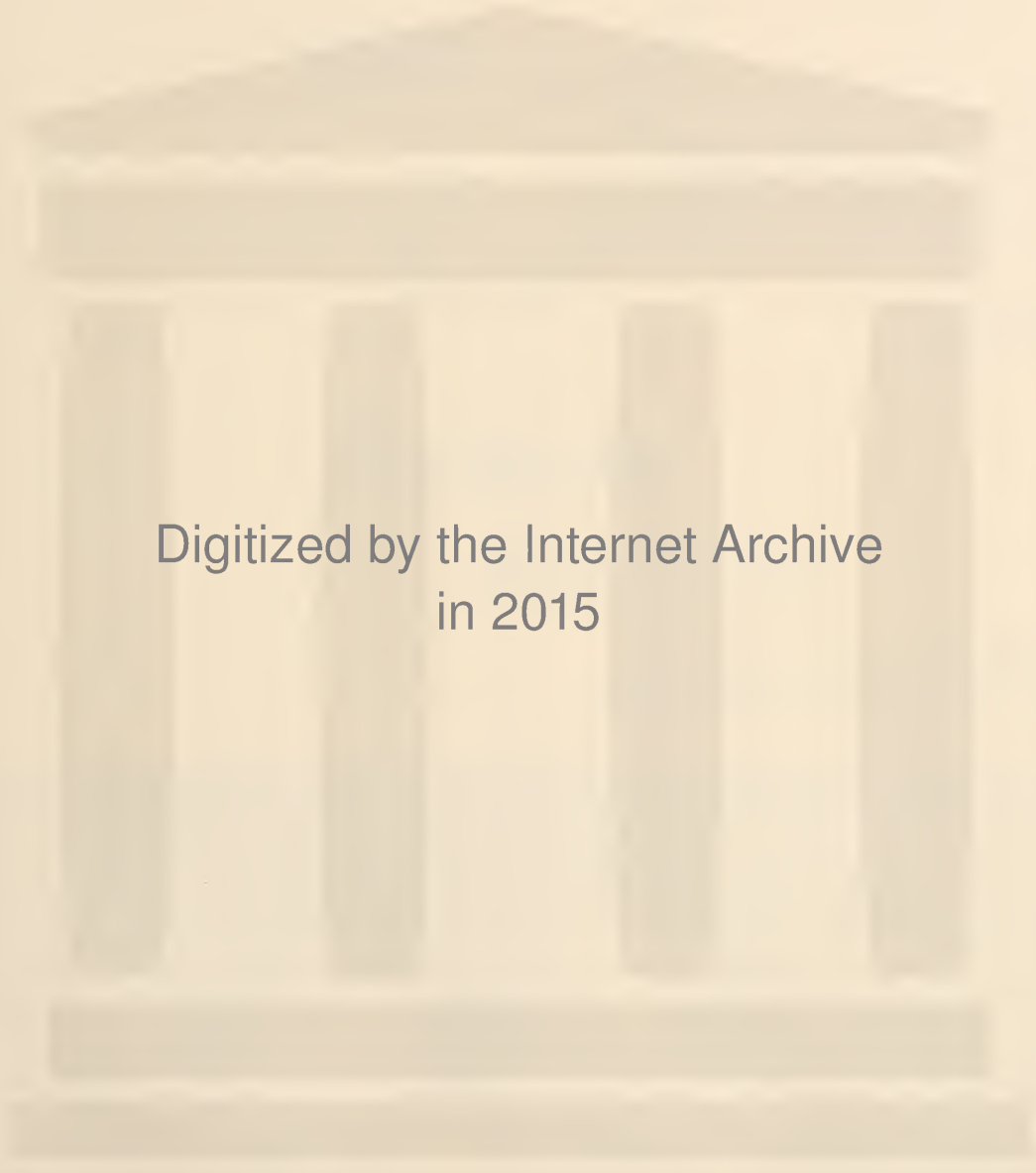
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inside as well as outside the hospital...
staphylococci usually remain sensitive to

CHLOROMYCETIN

(chloramphenicol, Parke-Davis

That the sensitivity patterns of "street" staphylococci differ widely from those o "hospital" staphylococci is a well-established clinical fact.[1-5] Although strains o staphylococci encountered in general practice have remained relatively sensitive t a number of antibiotics,[6] the problem of antibiotic-resistant staphylococci appear to be a threat to all patients in hospitals today. It is encouraging to note, however "...that a relatively small percentage of strains develop resistance to chloram phenicol, despite the consumption of large amounts of this antibiotic."[7]

In one hospital, for example, CHLOROMYCETIN "...was the only widely use antibiotic to which few of the strains were resistant."[8] In another hospital, despit steadily increasing use of CHLOROMYCETIN since 1956, "...the percentage o chloramphenicol-resistant strains has actually been lower in subsequent years." Elsewhere, insofar as hospital staphylococci are concerned, it appears that "...th problem of antibiotic resistance can be regarded as minimal for chloramphenicol."

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, includin Kapseals® of 250 mg., in bottles of 16 and 100.

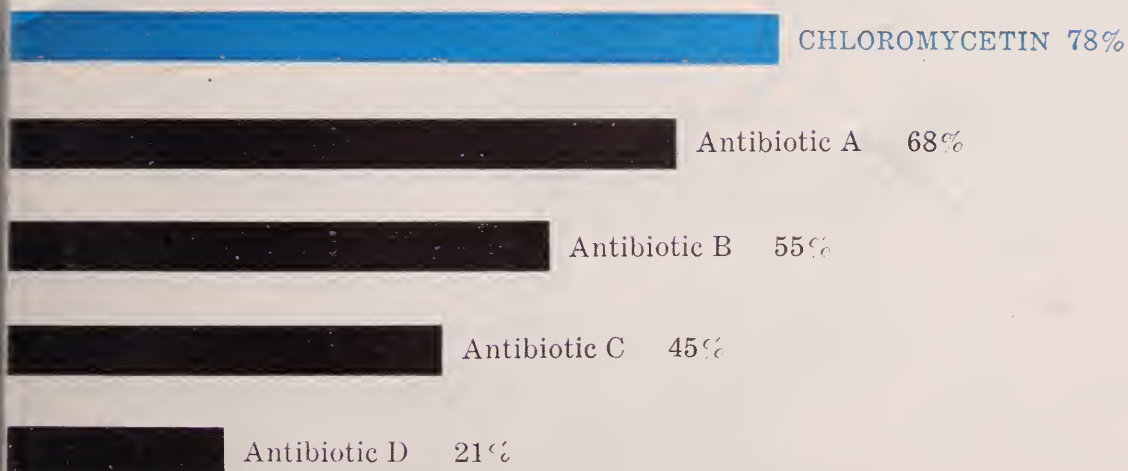
See package insert for details of administration and dosage.

Warning. Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias hav occurred after short term and with prolonged therapy with this drug. Bearing in mind the possibility tha such reactions may occur, chloramphenicol should be used only for serious infections caused by organism which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other les potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influ enza, viral infections of the throat, or as a prophylactic agent.

Precautions. It is essential that adequate blood studies be made during treatment with the drug. Whil blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, befor they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior t development of aplastic anemia.



IN VITRO SENSITIVITY OF 250 STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN AND TO FOUR OTHER ANTIBIOTICS*



These strains of coagulase-positive staphylococci were isolated from hospitalized patients at a large county hospital during the year 1959. Sensitivity tests were done by the disc method.

Adapted from Bauer, Perry, & Kirby[1]

References: (1) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (2) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960. (3) Cohen, S.: *Circulation* 20:96, 1959. (4) Edwards, T. S.: *Am. J. Ophth.* 48, Part II:19, 1959. (5) Smith, I. M.: Staphylococcal Infections, Chicago, The Year Book Publishers, Inc., 1958, p. 148. (6) Petersdorf, R. G.; Rose, M. C.; Minchew, H. B.; Keene, W. R., & Bennett, I. L., Jr.: *Arch. Int. Med.* 105:398, 1960. (7) Editorial: *J.A.M.A.* 173:544, 1960. (8) Finland, M.; Jones, W. F., Jr., & Bennett, I. L., Jr.: *Arch. Int. Med.* 104:365, 1959.

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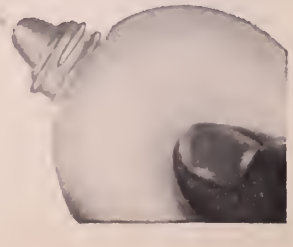
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VOLUME XLVIII, No. 1

• July, 1961

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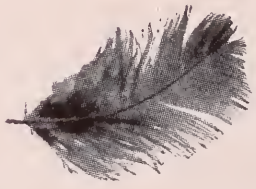
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References: (1) Lieberman, J. S.: GP *21*:133-143 (March) 1960. (2) DeWeese, J. A.: New England J. Med. *262*:1214-1217 (June 16) 1960. (3) Winsor, T.: Peripheral Vascular Diseases: An Objective Approach, Springfield, Illinois, Charles C Thomas, 1959, pp. 457-458. (4) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (5) Clarkson, I. S., and Le Pere, D. M.: Angiology *11*:190-192 (June) 1960. (6) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *17*:142-145 (Sept. 12) 1959.

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References: 1. Garber, R. C.: J. Florida M. A. *45*:549 (Nov.) 1958. 2. Lipton, M. I.: Pennsylvania M. J. *64*:60 (Jan.) 1961. 3. Ayd, F. J., Jr.: Psychotropic Drugs, S. Garattini and V. Ghetti, eds., New York, Elsevier Publishing Co., 1957, p. 548. 4. McGettigan, D. L.: West. Med. *1*:8 (Jan.) 1960.

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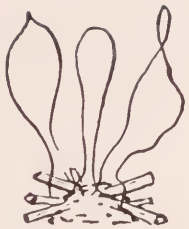
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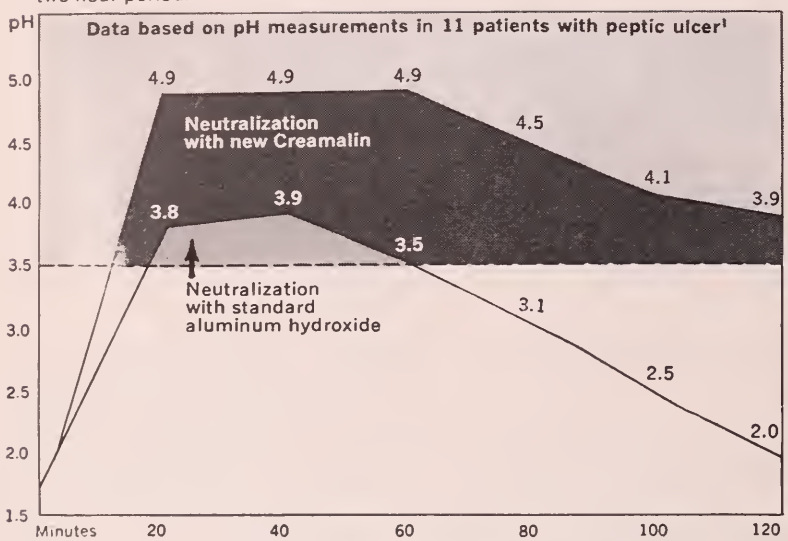
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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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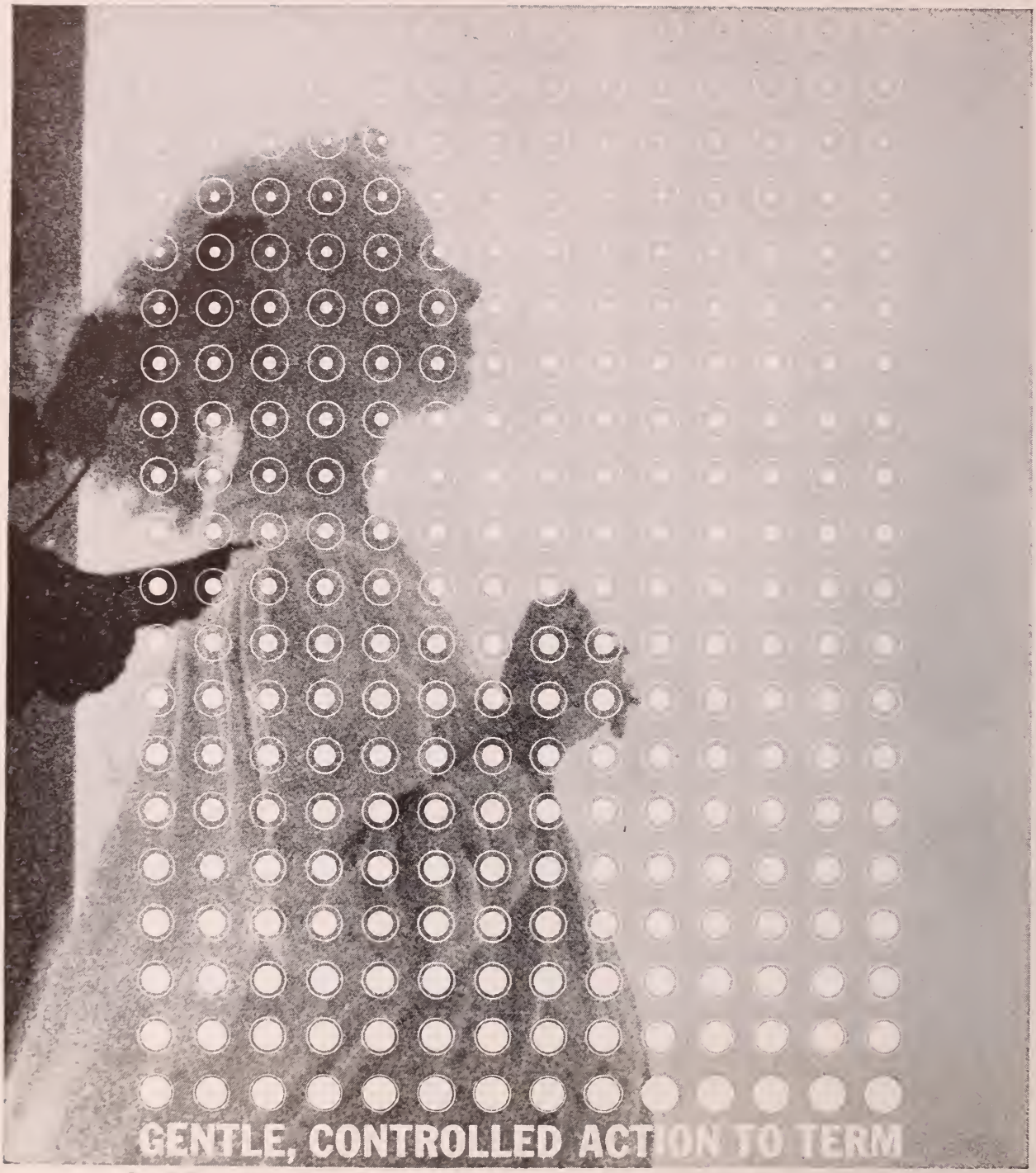
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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Volume XLVIII, No. 1, July, 1961

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LEO M. WACHTEL, M.D.
JACKSONVILLE

Mr. Speaker, members of the House of Delegates and of the Florida Medical Association, honorable guests and visitors, members of the Woman's Auxiliary:

The presence here of so many of you by choice when only the members of the House of Delegates are here by necessity is flattering. This is, therefore, a captive audience only in part. My remarks, on the other hand, might be termed a command performance, inasmuch as among the duties of the President of this Association is included, "He shall deliver an address at the annual meeting of the House of Delegates." I shall stick to the letter of the rule. This address, however, shall be distinguished by its brevity.

During this past year, your Association has operated for the first time under a new revised Charter and By-Laws approved by this House of Delegates in 1959 and subsequently ratified by the required three fourths of the component county medical societies. This has been a year devoted to the implementation of the provisions of that Charter and By-Laws, through which the Committee Chairmen, meeting under their respective Councils, formulated the policies and procedures of the Councils, to carry out the varied responsibilities of your Association.

The thoroughness with which this objective has been accomplished speaks well for the diligence and devotion displayed by those who so successfully met the challenge of this task. I would pause at this point to extend the thanks of the Association to the members of the Councils for their pioneering efforts which have so effectively built the broad highways for us to follow through the wilderness of Articles, Chapters and Sections.

Permit me also to note in passing that the few amendments to the By-Laws recommended by the Board of Governors to this House and printed in your Handbook on pages 50 and 51 bespeak the exactitude displayed by those who were responsible for the revised By-Laws. I congratulate them.

While I am passing out bouquets, I would be remiss if I did not publicly declare my great debt to the members of the Board of Governors and the Officers of the Association who have so loyally attended to the duties of office beyond requirements. I am also grateful for the competent functioning of all Committees and those who enthusiastically served on them. I would thank those of you who, holding no elected or appointed position, have as members of the Florida Medical Association encouraged me or constructively criticized me that I might better perform the duties of my office.

I thank you for the privilege and honor of having served as President of this Association. I entered this office in humility, born of ignorance, plus the knowledge that my predecessors were great presidents. I prepare to leave this office still humble in the light of so many jobs still undone, so many problems still unsolved.

But I take great hope. The stabilizing and continuing thread that runs through the years in our Association is the consistently efficient headquarters staff, headed by Mr. W. Harold Parham, Executive Director. He is a jewel in a setting of his own creation, and it is a thing of beauty. To

Read before the Florida Medical Association, Eighty-Seventh Annual Meeting, Bal Harbour, Miami Beach, May 25, 1961.

this headquarters staff one might apply that wartime service group's motto, "The difficult we do at once. The impossible takes a little time." To these men and women, I am eternally grateful, beyond expression.

In 1959, upon nomination of the Board of Governors and approval of the House of Delegates, the first Certificate of Merit was presented to Dr. Edward Jelks, recognizing exceptional and outstanding service to the Association, to the medical profession and to the public. Another Certificate of Merit has just been presented to Dr. Shaler Richardson. In addition, pursuant to a resolution out of the Orange County Medical Society, the Board of Governors recommends the establishment of a "Certificate of Appreciation" to recognize members of the Association for exceptionally meritorious service. It is proposed that this award will be made to those who render service to the Association over the years, not having had the privilege of serving as officers or being otherwise recognized.

A member of your Association, Dr. James T. Cook Jr., has in the past year, as you have seen and heard, been chosen American Medical Association General Practitioner of the Year upon nomination of your Board of Governors from nominees submitted to it. You have just witnessed the well deserved presentation of the Robins Award for outstanding community service to Dr. Edward R. Annis.

I call these various awards to your attention to expound for a moment upon the theme of service. Perhaps these remarks might better be directed to those who are not here. The opportunities to serve beyond the traditional service we render our patients are endless.

This Association, as well as all of organized medicine, needs physicians to apply their time and talents to improving the social, economic and political face that we show the public to the end that the "doctor image"—a much put-upon expression—may be altered, for the better. It is encouraging to learn (and I am grateful that the office of President of your Association has afforded me the chance to learn) that there are many physicians in the state who, unacclaimed and unappreciated, are performing notable work outside the profession in their communities and on broader fronts, in such varied capacities as benefactors and patrons of the arts, elected and appointed public officeholders, public relations promoters, political lobbyists, college alumni leaders, and teachers. The field is wide open.

For the past several years, organized medicine has waged a battle of opinions and beliefs with those officials in Washington who sincerely or otherwise are dedicated to the idea that the federal government knows better how to do these things which the people of this nation, individually or through their local or state governments, have been doing for themselves for more than 150 years before 1932 A.D. Our "big brother" in the District of Columbia takes a back seat to no one in knowing what is best in any field of endeavor and that includes the practice of medicine, provided, of course, that the people are willing to pay for it. And many people are willing, it seems. A host of people have been so spoon-fed since 1932 by good old Uncle Sam that they have long ago given up their birthright to provide for themselves and their loved ones. They make no pretense of providing for their own future security. They have lost the will to succeed by their own efforts, and the virtues and values that made this country great have atrophied from disuse. The do-it-yourself kits for individual initiative and independent enterprise have all but been made illegal. The primary interest of the something-for-nothing leeches as far as the government is concerned is to get as much as they can from the paternalistic table laden with national handouts, and to contribute as little as they can get away with. This is a national dogma? No, this is a national disgrace.

And who is the whipping boy for the propagandists who would benevolently take care of our senior citizens, however inadequately? The American Medical Association is the whipping boy. And what is the plan of the propagandists? Divide and conquer. It is to separate the doctors represented by the American Medical Association from their patients, the voting public.

This is where you and I come in. It is a mirage to look to the American Medical Association as the protector of the American way of practicing medicine, for the American Medical Association is composed of doctors like you and me, and the whole cannot be stronger than its component parts. We cannot all go to Washington and lobby or appear before committees; we cannot all slay dragons on television like Ed Annis can; we cannot all sit in the American Medical Association Board of Trustees or House of Delegates, setting policies; but we can all exert a personal patient-doctor influence. And it is here at the grass roots that the battle can be won or lost.

It is here in the confidential, intimate rapport that you who think you are serving least can serve best. If each physician made this sort of approach on a person to person basis with missionary zeal, the problem of influencing public opinion to favor our point of view would be easily solved.

It is not a new frontier that we seek, but a new enlightenment—a new understanding by the public of the physician's philosophy of medical care for all.

Thank you for your indulgence.

Proceedings
Eighty-Seventh Annual Meeting
Florida Medical Association
Bal Harbour, Miami Beach, May 25-28, 1961
General Session

The General Session of the Eighty-Seventh Annual Meeting of the Florida Medical Association was called to order at 4:30 p.m. Friday, May 26, 1961 in the Grand Ballroom, Americana Hotel, Bal Harbour, Miami Beach, by President Leo M. Wachtel.

Dr. Wachtel: "This session is devoted to one purpose, and that is to welcome and to hear the President's guest speaker. Members of the Florida Medical Association, its Auxiliary, guests, ladies and gentlemen:

"To enumerate the many notable events and distinguished accomplishments in the life of our guest speaker would serve only to repeat that with which all of you are familiar, also to delay the dissertation that you came to hear. Members of the medical profession are continuously called upon to make difficult choices and decisions in their professional life, but our profession holds no monopoly in this respect. Senators have problems in making the right choice too. Many of these would naturally be of far-reaching consequence as our guest speaker can testify convincingly by merely cataloguing the mail received daily from his constituents and voters at his Senate office in Washington. For example, working tax-payers in Florida ask for tax reduction, while many retired people seek the expenditure of more federal funds for welfare benefits; barge and other waterway shipping operators beg for a cross-state canal, while the railroads and others in the transportation industry vigorously oppose such a project; some of Floridas' citizens are critical of the administration's cautious foreign policy regarding Cuba, Laos and the Congo, while others advise very gentle diplomacy; the average pleasure car driver supports the additional highway tax on



Senator Smathers

truck tires, while the trucking industry writes their Senator predicting their own bankruptcy and other dire events if such a proposition becomes law; local Chambers of Commerce beseech their Senator to direct more and more Federal projects to their communities, while the National Chamber of Commerce demands governmental economy and fewer Federal projects everywhere. While we physicians have every confidence that George will continue to represent our viewpoint in the U. S. Senate on aid to the needy aged, President Kennedy expects George Smathers, his close personal friend, and George Smathers, Secretary to the Democratic Conference, a high party office, to help enact the administration's program, including compulsory health care for aged persons regardless of need. In spite of these conflicting demands, a Senator develops a character with the passage of time, based upon his reaction to his problems, as expressed in the views he declares. A Senator develops a philosophy by which he is classified by the public. From what I have heard and observed, our speaker has well established his reputation as a Southern conservative, and this is how I introduce him to you today. I am proud to present to you my good personal friend, George Armistead Smathers, the distinguished junior Senator from Florida."

Senator Smathers presented a stimulating address which captivated his audience. He reviewed the current political climate of Washington with regard to medical legislation and made his own gratifying position quite clear. He also gave an enlightening portrayal of present Latin-American relations and their worldwide implications. His remarks received wide acclaim.

Dr. Wachtel: "George, I think that the standing ovation you have just been given speaks how we feel about you here in the Florida Medical Association and certainly it speaks how I feel about you. We are happy that you could be with us; you have laid aside for us many fears, and we wish you godspeed.

"The meeting is adjourned."

First House of Delegates

The House of Delegates convened at 2:00 p.m. on Thursday, May 25, 1961, in the Grand Ballroom of the Americana Hotel, Bal Harbour, Miami Beach, Florida, with Dr. Joseph S. Stewart, Speaker of the House, presiding.

President Leo M. Wachtel presented a personal gavel to Dr. Joseph S. Stewart as first Speaker of the House of Delegates.

The invocation was delivered by Ralph B. Huston, D.D., Minister, First Methodist Church, South Miami: "O Lord, our God, the Great Healer and Good Physician of both body and soul, we turn to Thee for we recognize that Thou alone givest life and Thou alone dost sustain life. We would bless Thee, O Lord, and forget not all Thy benefits. Bless these doctors whom Thou hast called to minister to the sick and suffering. We are grateful for their devotion as they think Thy thoughts after Thee and search for the truths and acquire the skills which lead to healing. Add to their wills a readiness to follow Thy guidance; to their hearts, a compassion like unto that of the Great Physician, who ministered both lovingly and without favor. May this great convention be the means of adding to their skill and power, that they may exercise their art for the well-being of Thy servants and to Thy glory. Amen."

The Speaker announced the membership of the Credentials Committee: Drs. Hugh A. Carithers, Chairman, Clarence L. Anderson and Walter W. Sackett Jr.

The Chairman of the Credentials Committee, Dr. Hugh A. Carithers, reported that 148 delegates were presented and moved that they be seated. Motion was seconded and carried.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Walter E. Murphree, George H. Putnam.
BAY—*(Absent—Donald H. Anderson, Joseph H. Morris)*
BREVARD—Theodore J. Kaminski, Thomas C. Kenaston Sr., Arthur C. Tedford
BROWARD—Miles J. Bielek, Russell B. Carson, Frederick W. Fisher, Walter J. Glenn Jr., Russell R. Hippensteel, David J. Lehman Jr., John H. Mickley, Floyd A. Osterman, Leigh F. Robinson, W. Dotson Wells, Scottie J. Wilson
CHARLOTTE—Robert H. Shedd
CLAY—Thomas L. Glennan
COLLIER—John C. Garland
COLUMBIA—Laurie J. Arnold Jr.
DADE—Seymour L. Alterman, James L. Anderson, Edward R. Annis, Gunnard J. Antell, George S. Baldry,

Harry E. Beller, John E. Burch, Turner E. Cato, Francis N. Cooke, Richard C. Clay, Jack Q. Cleveland, Vincent P. Corso, Edward W. Cullipher, H. Clinton Davis, Robert F. Dickey, L. Washington Dowlen, Leon S. Eisenman, Franklin J. Evans, Willard L. Fitzgerald, Michael M. Gilbert, Milton S. Goldman, Maurice M. Greenfield, W. Tracy Haverfield, James J. Hutson, Truxton L. Jackson, Joseph T. Jana Jr., Christian Keedy, David Kirsh, Carlos G. Llanes, James K. McShane Sr., William T. Mixson Jr., Warren W. Quillian, George W. Robertson III, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Irvin Seaman, Winston K. Shorey, Clifford C. Snyder, William M. Straight, Collins W. Swords Jr., Herbert W. Virgin Jr., Arthur W. Wood Jr.

DESOTO-HARDEE-GLADES—Gordon H. McSwain

DUVAL—Frederick H. Bowen, Robert J. Brown, Hugh A. Carithers, Clyde M. Collins, Thomas S. Edwards, Emmet F. Ferguson Jr., Gordon H. Ira, Thomas M. Irwin, Edward Jelks, F. Gordon King, Samuel S. Lombardo, Harry W. Reinstine Jr., Sidney Stillman, G. Dekle Taylor, Ashbel C. Williams

ESCAMBIA—Egbert V. Anderson, P. G. Batson Jr., Luther C. Fisher Jr., George W. Morse, John M. Packard

FRANKLIN-GULF—John W. Hendrix

HIGHLANDS—C. Brooks Henderson

HILLSBOROUGH—Samuel H. Adams, C. Frank Chunn, Herschel G. Cole, Irving M. Essrig, H. Phillip Hampton, Linus W. Hewit, Herbert B. Lott, Eugene B. Maxwell, Madison R. Pope, Wesley W. Wilson, James A. Winslow Jr.

INDIAN RIVER—Erasmus B. Hardee Sr.

JACKSON-CALHOUN—James T. Cook Jr.

LAKE—Frederick C. Andrews *(Absent—C. McK. Tyre)*

LEE-HENDRY—Fred D. Bartleson, James L. Bradley

LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—Thomas J. Bixler, Nelson H. Kraeft, George S. Palmer, Hillard R. Reddick

MADISON—*(Absent—Julian M. DuRant)*

MANATEE—Irving E. Hall Jr., John A. Shively

MARION—William H. Anderson Jr., Henry L. Harrell

MONROE—Ralph Herz

NASSAU—Cecil B. Brewton

ORANGE—Frank C. Bone, Louis P. Brady, Chas. J. Collins, Norman F. Coulter, Harry H. Ferran, Louis C. Murray, Charles R. Sias, W. Dean Steward, Miles W. Thomley, Robert E. Zellner

PALM BEACH—Edwin W. Brown, James F. Cooney, William H. Everts, V. Marklin Johnson, Walter R Newbern, Ralph M. Overstreet Jr., Cecil M. Peek, Wiliam H. Proctor

PASCO-HERNANDO-CITRUS—Gail M. Osterhout

PINELLAS—Charles E. Aucremann, Edward L. Cole Jr., John P. Ferrell, Earl R. Fox, C. Gibson Hooten, William H. Keeler III, Jack A. MaCris, Norval M. Marr Sr., William G. Mason, George H. Schoetker, Robert T. Walker, Walter H. Winchester, Rowland E. Wood

POLK—Clarence L. Anderson, Newell J. Griffith, Charles Larsen Jr., Arthur J. Moseley Jr. *(Absent—Samuel J. Clark, Marion W. Hester)*

PUTNAM—Claude M. Knight

ST. JOHNS—Reddin Britt

ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Howard C. McDermid

SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Millard B. White

SEMINOLE—Daniel H. Mathers

SUWANNEE - HAMILTON - LAFAYETTE—Hugo F. Sotolongo

TAYLOR—John H. Parker Jr.

VOLUSIA—John J. Cheleden, C. Robert DeArmas, Richard C. Hartsfield, Achille A. Monaco

WALTON-OKALOOSA-SANTA ROSA—Frederic E. Caldwell *(Absent—Malcolm C. Crotzer)*

WASHINGTON-HOLMES—*(Absent—One delegate, name not submitted)*

COUNCIL ON SPECIALTY MEDICINE—Fred H. Albee Jr., William C. Blake, Michael A. DiCosola, Richard M. Fleming, T. Bert Fletcher Jr., J. Basil Hall, Samuel G. Hibbs, Richard S. Hodes, Willard E. Manry Jr., Ivan C. Schmidt, H. Lawrence Smith, John S. Stewart, I. Irving Weintraub *(Absent—Jack H. Bowen, Harry M. Edwards John B. Miale, Joseph E. O'Malley, Irwin Perlmutter, Don C. Robertson, Donald W. Smith, Kenneth S. Whitmer)*

STATE OFFICERS—Leo M. Wachtel, S. Carnes Harvard, Clyde O. Anderson, Ralph W. Jack, Samuel M. Day, Joseph S. Stewart, Eugene G. Peek Jr.

AMA DELEGATES—Francis T. Holland, Burns A. Dobbins Jr., Meredith Mallory *(Absent—Reuben B. Chrisman Jr.)*

The Speaker asked for a motion for the correction or adoption of the minutes of the 1960 meeting as published in The Journal.

Dr. W. Dean Steward of Orange moved that the minutes be adopted.

Seconded by Dr. Ralph W. Jack of Dade.

Dr. Franklin J. Evans of Dade read the following excerpt from the minutes of the 1960 meeting: (Column 1, page 1539, of the June 1960 Journal)

Dr. Harold W. Johnston of Orange: "I would like to make a motion that whoever loses the election for Speaker be unanimously elected as Vice Speaker."

Motion was duly seconded and carried.

Dr. Edward R. Annis of Dade: "I don't think this is a good idea. We are talking about a Speaker and a Vice Speaker from the same area of the state. Wouldn't it be wise to have, as in the case of the presidency and other offices, different sections of the state represented? There are several men in different areas who can bring to the position a lot of information of value, and at the same time develop leadership for the future in other sections of the state. I am automatically against electing two men for any office from any one area."

Dr. David R. Murphey Jr. of Hillsborough: "Mr. President, I move the motion be tabled."

Dr. Murphey's motion was seconded and carried and Dr. Johnston's motion to elect the loser Vice Speaker was tabled.

Dr. Evans then moved to correct the minutes by deleting the words "and carried" following Dr. Johnston's motion, as one cannot table a motion that has already been carried.

By voice vote, the minutes of the 1960 meeting were approved as amended.

The Speaker introduced Dr. Willard L. Fitzgerald, President of the Dade County Medical Association, the host society, who gave the address of welcome.

"President Wachtel, Speaker Stewart, Delegates to the Florida Medical Association and

guests: To welcome the Florida Medical Association to Dade County is like the welcome one would give to his father—after the old man had been away from home for two years.

"Things have changed at home since you were here; in fact, they have changed throughout our whole land, and apparently for the worse. For proper perspective, perhaps, I should welcome you now to the third most confused area of the whole world—first, Washington; second, Tallahassee, and last, Miami and Dade County.

"I can speak more authentically of the last—our local area. The best place to start would be to recall what Shakespeare's witches had to say as they stirred the boiling pot: "Double, double toil and trouble; Fire burn, and cauldron bubble."

Locally, we do have troubles—double troubles—while the fire burns and the cauldron bubbles

We have:

Double government,
Double taxation,
Trial and error,
Fumble and confusion, and
Refugees

"In our last Sunday's paper there was an article about the Alaskan Eskimos. An Eskimo was accosted by a government agent for killing game to feed his family. 'What do you mean' he said, 'My people have always hunted game to feed their families. When our children get hungry, we kill game to feed them. It has always been so.' 'No,' said the government agent to the citizen of the forty-ninth state, 'do not kill game. If you get hungry go down to the government relief station—they will give you food and a government check.' "

"It seems that everyone will get consideration—and aid—except the fellow who works, assumes his responsibility as the head of a family and as a citizen, and tries to provide for his own future.

"Gentlemen, not only locally, but statewide and nationally, a strange sort of philosophy is permeating our land. We have double talk, gobbledegook, minority rule, something-for-nothing, labor overlords who assume unearned authority, cradle-to-the-grave programs, compromise, and appeasement. Unless these things are changed, the United States of America is sunk. Harvard phraseology will not save our country. We need action for what we know is right.

"Your host society welcomes you, in the hope that something in the way of proper influence can come out of your meeting."

The Speaker introduced the officers seated on the rostrum: President Leo M. Wachtel, Vice President Clyde O. Anderson, Secretary-Treasurer Samuel M. Day, Vice Speaker Eugene G. Peek Jr. and Mr. W. Harold Parham, Executive Director. Dr. S. Carnes Harvard, President-Elect, was absent attending the funeral of Dr. Louis M. Orr.

The Vice Speaker read the following telegram:

Dr. Joseph S. Stewart, Speaker
House of Delegates
Florida Medical Association
The Americana Hotel
Miami Beach, Florida

TO YOU, MR. SPEAKER, VICE SPEAKER PEEK, PRESIDENT WACHTEL, PRESIDENT-ELECT HARVARD, MR. PARHAM, EXECUTIVE DIRECTOR, AND TO ALL OFFICERS, DELEGATES, MEMBERS OF THE FLORIDA MEDICAL ASSOCIATION, MY BEST WISHES FOR A MOST SUCCESSFUL MEETING. HOSPITALIZATION PREVENTS MY ATTENDANCE. I JOIN WITH YOU AND ALL OF OUR COLLEAGUES IN EXPRESSING GRATITUDE TO DR. E. VINCENT ASKEY, PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION FOR HIS PRESENCE.
Reuben B. Chrisman Jr.

Dr. Gordon H. Ira of Duval moved that the order of business as published in the Handbook be accepted for the meeting.

Motion seconded and carried.

Dr. Stewart: "Ladies and Gentlemen:

Remarks of the Speaker

JOSEPH S. STEWART, *Speaker*

Referred to: Reference Committee No. III
Finance and Administration

Your Speaker and Vice Speaker welcome you to the first Annual Meeting of the House of Delegates of the Florida Medical Association held under the new charter and By-Laws.

There are two changes which affect the House of Delegates and which I would like to bring to your attention. First, the election of a Speaker and Vice Speaker to preside over the meetings of the House of Delegates. This action gives your President more time for his many, many duties and besides it gives him an opportunity to debate any proposals which are presented to the House. Heretofore your President, as presiding officer of the House of Delegates, had to maintain a neutral position in all questions and he was thus limited from giving you, the members of the House of Delegates, the real benefit of his hard work and knowledge. Your Speaker believes that this will add to the efficiency of your organization.

Second, the new By-Laws provide for an addition to the House of Delegates in making ex officio members the chairmen of all specialty groups as recognized by the Board of Governors. Up to this time the Board of Governors has recognized 21 specialty groups and thus 21 ex officio members of the House of Delegates have been added with all the rights and privileges of other delegates. This provision should perhaps be carefully observed during the next several years since what we might call this unlimited power of the Board of Governors to add to the House of Delegates is potentially dangerous.

The Speaker would like to urge all delegates and all members of the Association to appear before any of the Reference Committees with the full privileges of the floor to give their points of view on any question which appears before the Committees. The Speaker recommends careful study of the resolutions which appear in the

Handbook as a prelude to appearing before the Reference Committees.

All reports and resolutions received too late to be published in the Handbook but received in time to be duplicated in the home office are in your delegates' packets.

The Speaker is pleased to call to your attention a letter in your packet advising of an insurance policy which protects you while attending this meeting as an official delegate.

Your Speaker and Vice Speaker assure you that each will preside according to the principles of recognized parliamentary procedure, keeping in mind always that each of us must bow our heads to the will of the majority; that all members have equal rights, privileges and obligations and that the minority has rights which must be protected and must not be infringed upon.

The Speaker urges each of you, if at any time you disagree with any ruling or decision of the Speaker, please to feel free to question the decision or to appeal from the decision so that it can be immediately put to a vote of the House. It is the duty of any presiding officer to expedite the business of an organization; therefore certain shortcuts are permissible when there are no objections. For this reason the Speaker begs you to object at any time you feel a question should be debated.

The Speaker recognized Dr. Thad Moseley, Chairman of the Scientific Council, who briefly outlined the scientific program for the meeting.

The Speaker recognized Mrs. John M. Butcher, President of the Woman's Auxiliary to the Florida Medical Association, and Mrs. W. Dean Steward, President-Elect.

Dr. Harry B. O'Rear of Augusta was recognized as fraternal delegate from Georgia.

The Speaker asked Dr. James T. Cook Jr. of Marianna to stand and be recognized as the recipient of the American Medical Association's award "General Practitioner of the Year."

The Vice Speaker then read the names of members who have been honored during the year by other organizations:

Honorary Citations
Florida Medical Association Members

DAUGHTRY, DeWITT C., MIAMI—Elected President of the Southern Thoracic Surgical Association at its meeting in Nassau.

FLIPSE, M. JAY, MIAMI—On Saturday, June 11, 1960, took office as President of the American College of Chest Physicians.

GRAY, CHAS. McC., TAMPA—Elected President-Elect of the Radiological Society of North America to assume the Presidency in 1961.

HALLSTRAND, HAROLD O., SOUTH MIAMI—On September 28, 1960, was appointed Regent for the Florida State Surgical Division, United States Section of the International College of Surgeons.

MILLARD, D. RALPH JR., MIAMI—Appointed Honorary Consultant in plastic surgery to the Government of Jamaica.

PATTERSON, JAMES N., TAMPA—Elected to his second six-year term as a trustee member of the American Board of Pathology.

PATTERSON, JOHN C., SARASOTA—Received a second diploma in honor of his fiftieth graduation anniversary from Tulane University on May 30, 1960.

SACKETT, WALTER W. JR., MIAMI—Elected to the Board of Directors of the American Academy of General Practice at its 1960 annual meeting.

DELL, J. MAXEY JR., GAINESVILLE—Elected to the Board of Chancellors of the American College of Radiology.

The Speaker recognized the President of the Florida Medical Association, Dr. Wachtel.

Dr. Wachtel: "I would read you a resolution which is actually being presented out of order and I will then ask that the rules be waived so that it may be acted upon at this time.

SUBJECT: Nomination of Shaler Richardson, M.D.
to receive the second
Florida Medical Association Certificate of Merit

SUBMITTED BY: The Board of Governors
See report of Board

WHEREAS, Shaler Richardson, M.D., of Jacksonville, a distinguished life member of the Florida Medical Association, has rendered outstanding service to the medical profession, to the public, and especially to the Association throughout the thirty-nine years of his membership, and is therefore worthy of the Association's highest tribute;

WHEREAS, This eminent physician, born in Lake Charles, Louisiana, on February 27, 1891, was the son of a prominent physician there and the nephew of a well known Florida physician, was awarded the degree of Doctor of Medicine by Vanderbilt University School of Medicine in 1913, served a two year internship at the Memphis City Hospital, then served his country in World War I for two years as a major in the Medical Corps of the United States Army, and thereafter was a resident for four years at the New York Eye and Ear Infirmary;

WHEREAS, In 1922, this noted doctor entered the private practice of medicine in Jacksonville, was elected Secretary-Treasurer of the Florida Medical Association and Editor of The Journal of the Florida Medical Association in 1925, served in this dual capacity for nineteen years, held numerous regular and special committee assignments through the years, became President-Elect in 1944 and held that office for two war years, served as President in 1946, resumed the post of Editor of The Journal in 1947 and continued to serve in that official capacity until the present time;

WHEREAS, This faithful servant of Medicine has filled important posts throughout his career in the organizations of his specialty and has long been a leading figure in every type of work for the blind, was a charter member and is a past president of the Florida Society of Ophthalmology and Otolaryngology, is a former member and a past president of the Florida State Board of Health, is a past president of the Duval County Medical Society, has filled with distinction the highest staff positions of the hospitals of his community, and has received wide recognition in local, county, state and national medical organizations for his loyal service and unflagging zeal;

WHEREAS, This distinguished physician became the second Editor of The Journal only eleven years after its founding, has during his thirty-three years at its helm guided this organ of the Association to a place of prominence among state medical journals which reflects great credit on his leadership, and today assumes the post of Editor Emeritus by appointment of the Board of Governors; Therefore, be it

RESOLVED, That the Certificate of Merit, the Association's highest honor, be awarded to this untiring devotee of the healing art, exemplary member and faithful officer of the Association, dedicated Editor of The Journal, and devoted servant of the public, in recognition of his unselfish service, prodigal expenditure of time and talents, personal sacrifices, and countless contributions to

The Journal, to the progress of the Association, to the betterment of organized medicine and to the welfare of the public.

"Mr. Speaker, I move that the rules of this House be waived and this resolution be adopted at this time."

Motion seconded and carried.

By voice vote, the resolution was unanimously adopted.

Dr. Richardson was asked to come to the rostrum.

Dr. Wachtel: "Dr. Richardson, you do us honor by accepting this Certificate of Merit."

Dr. Richardson: "Mr. President, Members of the Board of Governors and the House of Delegates, I thank you from the bottom of my heart. I have loved the work in the Association; it has meant much to me. Thank you."

Dr. Wachtel then presented checks from the American Medical Education Foundation to Dr. Homer F. Marsh, Dean, University of Miami School of Medicine, and to Dr. George T. Harrell, Dean, University of Florida College of Medicine.

Dr. Wachtel: "This year the A. H. Robins Company has instituted a Community Service Award to honor a physician in each state judged by his colleagues to have contributed most significantly to civic activities. It is my understanding that Mr. E. C. Robins, the president of the company, who conceived this award intends that this distinction serve to correct a false public impression of the physician as an aloof and self-centered professional, by calling attention to his widespread interest and involvement in public affairs.

"Today, we are presenting the first Community Service Award in Florida, which is the sixth to be presented in the nation. The recipient of the Award was selected by the Board of Governors from nominees submitted by the various county medical societies. Unanimously chosen was Edward R. Annis, M.D., of Miami.

"Ed, a medical graduate of Marquette University School of Medicine has come into prominence in recent years as a debater of outstanding ability, much to the chagrin of such renowned opponents as Averill Harriman, Walter Reuther, and Senators McNamara, Javits, Proxmire and Humphrey. Ed is chairman of the American Medical Association's Speakers Bureau. Secretary of Health, Education, and Welfare Ribicoff, recognizing Ed's attainments, has refused to meet him in public debate. In respect to helping to prevent the socialization of medicine, Ed has served the public as well as the profession.

"Before moving to Miami in 1946, our award winner practiced for eight years in Tallahassee where he first gave concrete evidence of the belief that even busy physicians should not neglect civic responsibilities. He served as president of the Tallahassee Junior Chamber of Commerce and held other high positions in the state and national Junior Chambers of Commerce, the Tallahassee Chapter of the American Red Cross, the Tallahassee Tuberculosis Association and the Kiwanis Club.

"Moving to Miami in 1946, our Ed continued his activities in the Chamber of Commerce and the Kiwanis Club. In addition, he moved into political aspects of community service, being appointed by Governor Collins in 1955 to the Dade County Budget Commission and in 1959 to lead the Florida Citizens Medical Committee on Health. For the past two years he has served an appointment as a member of the Dade County Metropolitan Government Hospital Advisory Board, and for the past six years on the Board of Directors of the Senior Citizens Division of the Welfare Planning Council. In 1958, the Florida Region group of the National Conference of Christians and Jews honored Ed with a Brotherhood Award for his work in Community Relations.

"In 1950, Dr. Annis campaigned vigorously in electing Senators Smathers over Claude Pepper, an advocate of an unwise method of medical care. Ed attended the 1960 Democratic National Convention as an alternate delegate and argued vehemently before the Platform Committee against Forand type proposals.

"Ed is a member of several surgical organizations and has served the Dade County Medical Association as a member of its Board of Directors and as a delegate to this House of Delegates. He has filled many effective roles in the Florida Medical Association and is presently Chairman of our State Legislative Committee.

"It is therefore with a tremendous feeling of gratification that on behalf of the A. H. Robins Company, I present this plaque for distinguished community service to Edward R. Annis, dedicated surgeon, devoted father, talented tennis player, exemplary citizen and public servant. Ed, our sincere congratulations, our deep admiration, and our very great affection."

Dr. Annis: "These days I never turn down a chance to talk to a captive audience. Less than an hour ago I returned from Detroit. In accepting this honor which reflects what I have heard

from so many of you, may I at least take this opportunity to let you know that within the last six weeks it has been my pleasure to speak in 26 cities, 12 states and the District of Columbia. In every one of these places, there are doctors and their wives and those associated with the medical field who feel just as strongly as do we that there is a real battle going on at the present time and a real battle ahead. Doctors are citizens, too, and we must take a little more time from our practices to spread the words which we know to be true among ourselves, among our friends and among our neighbors. I hope that in the opportunities which have been presented that I am faithfully reflecting the views of my fellow physicians. Again, many thanks."

Dr. Stewart: "It is now the pleasant privilege and duty of your Speaker to introduce to you your President for his annual address. May I say in this introduction that the presidency of this organization is a real honor, and the recipient of that honor really puts out work. Not many of us realize how much work is involved. Ed Annis gives you an idea of how much work you can do.

"Incidentally, Mr. President, Ed just stole a word that I was going to use, "captive audience." I want to say in passing that you have a beautiful captive audience. When I was president, the president made his address at a scientific meeting and at my address were present my wife, Walter Payne, Reuben Chrisman, and four people who didn't know where else to go. I had worked a whole year on that address and was pretty sick that nobody heard it. We took it up with the Board of Governors; they saw how incensed I was, and finally the Board of Governors made a rule that the President would have a captive audience and make his address before the House of Delegates, which would really appreciate what he had done.

"May I say that your President, who comes from Duval County, joins a list of illustrious men —the ones that I have known—Marshall Taylor, Gerry Holden, Fred Waas, Ed Jelks, Shaler Richardson and Bob McIver. The last three named are here today.

"Mr. President, you have added luster to the history of Florida medicine.

"Ladies and Gentlemen, the President of the Florida Medical Association, Dr. Wachtel."

(The complete text of the presidential address appears on page 21). The President's address was assigned to Reference Committee No. III. Dr. Stewart announced the personnel of Reference Committees as follows:

I. HEALTH AND EDUCATION
- Henry L. Harrell, Chairman
- Thomas M. Irwin
- James L. Bradley
- Frank C. Bone
- Maurice M. Greenfield

II. PUBLIC POLICY
- Francis N. Cooke, Chairman
- George W. Morse
- Fredrick C. Andrews
- Charles R. Sias
- Clifford C. Snyder

III. FINANCE AND ADMINISTRATION
- Miles J. Bielek, Chairman
- Nelson H. Kraeft
- Linus W. Hewit
- Ralph S. Sappenfield
- Ralph M. Overstreet Jr.

IV. LEGISLATION AND MISCELLANEOUS
- Eugene B. Maxwell, Chairman
- James T. Cook Jr.
- John P. Ferrell
- James F. Cooney
- Vincent P. Corso

The following council and committee reports and resolutions were referred as published in the Handbook, together with supplemental reports and additional resolutions as presented in the delegates packets.

The Speaker asked if there were any additional supplemental reports or resolutions.

Dr. John M. Gunsolus, of St. Lucie-Okeechobee-Martin County Medical Society, presented a resolution on general practice residencies. No. 61-19 was assigned to this resolution and it was referred to Reference Committee No. I.

Dr. Frederick W. Fisher, of Broward, introduced two resolutions. The first recommended the development in each of the component county medical societies of a committee on voluntary prepayment for the purpose of assisting in the arbitration and investigation of claims. This was assigned to Reference Committee No. IV and designated as Resolution No. 61-21.

The second resolution recommended a new Blue Shield contract with a $6,000 service limit. This was also assigned to Reference Committee No. IV and given No. 61-20.

Dr. H. Phillip Hampton, Chairman of the Legislative Council gave a supplemental report on national and state legislation which was referred to Reference Committee No. IV.

Dr. Burns A. Dobbins Jr. gave a report on Medicare, which was not referred as it was already covered by his report as printed in the Handbook.

Dr. Day presented a supplemental report of the Board of Governors in which the Board re-

ferred to the House of Delegates a matter which came from the American Academy of Orthopedic Surgeons regarding Podiatry—a statement of policy by the American Academy of Orthopedic Surgeons on the practice of Podiatry in hospitals. Dr. Day read the statement of policy, which was referred to Reference Committee No. II.

Dr. Clifford C. Snyder, Chairman, Committee on Archives, presented a supplemental report which was referred to Reference Committee No. III.

At this time the Speaker declared a 10 minute recess.

The Speaker recognized Dr. Homer L. Pearson Jr. of Dade County, who read a resolution in memory of Dr. Louis M. Orr.

We are opening this session of the House of Delegates of the Florida Medical Association today on a note and in an atmosphere of gloom and sorrow for last Monday night in Orlando, Florida, our most distinguished member, Louis M. Orr, died of a coronary.

He spent his full professional life in Orlando where he not only created a most successful urological practice but established himself as one of Orlando's, as well as Florida's, most outstanding citizens.

He has served organized medicine during his entire professional life at all levels; from the "grass roots" of the county medical society, of the state association, of his specialty societies, to that of the top post.

He has served the cause of medicine with willingness, with eagerness and with devotion, being ever an advocate of adequate medical care for all the people.

His life of service as a soldier, as a civilian and as a scientist marks him as one of the great men of our time. His life was an example and an inspiration for all who knew him. He was a devoted husband and father and a champion for the cause of right and justice.

His passing casts a heavy shadow over all of us here, but we can be happy in the knowledge that he ran a good race, and fought a good fight, and that he enters into his reward with the voice of his Lord saying "well done thou good and faithful servant;" therefore, be it

Resolved, That this body rise in humble tribute to him; and

That a similar statement be presented at the next meeting of the House of Delegates of the American Medical Association; and

That a copy of this paper be presented to his family with the sympathy of this Association; and

That a copy be placed in the minutes of this meeting.

Dr. Stewart: "Gentlemen, you will vote by standing and bowing your heads."

The Speaker presented Dr. S. Carnes Harvard, President-Elect, who was absent during the introductions earlier in the meeting.

Dr. Wachtel introduced Dr. E. Vincent Askey, the President of the American Medical Association, who presented an inspiring address.

Dr. Homer L. Pearson Jr. gave a brief report as Secretary of the State Board of Medical Examiners and a supplemental report as Chairman of the Judicial Council, which were referred to Reference Committee No. III.

The House of Delegates recessed at 4:25 p.m. to reconvene on Sunday, May 28, 1961 at 1:30 p.m.

Second House of Delegates

The House of Delegates reconvened at 1:30 p.m. on Sunday, May 28, 1961, in the Grand Ballroom of the Americana Hotel, Bal Harbour, Miami Beach, with Dr. Joseph S. Stewart, Speaker of the House, presiding.

The Chairman of the Credentials Committee reported that there were 165 delegates present and of 206 Delegates, 189 had been seated.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Walter E. Murphree, George H. Putnam
BAY—Donald H. Anderson *(Absent—Joseph H. Morris)*
BREVARD—Theodore J. Kaminski, Thomas C. Kenaston Sr., Arthur C. Tedford
BROWARD—Miles J. Bielek, Russell B. Carson, Frederick W. Fisher, Walter J. Glenn Jr., Russell R. Hippensteel, David J. Lehman Jr., John H. Mickley, Floyd A. Osterman, Leigh F. Robinson, W. Dotson Wells, Scottie J. Wilson
CHARLOTTE—*(Absent—Robert H. Shedd)*
CLAY—Thomas L. Glennan
COLLIER—John C. Garland
COLUMBIA—*(Absent—Laurie J. Arnold Jr.)*
DADE—Seymour L. Alterman, James L. Anderson, Edward R. Annis, Gunnard J. Antell, George S. Baldry, Harry E. Beller, John E. Burch, Turner E. Cato, Francis N. Cooke, Richard C. Clay, Jack Q. Cleveland, Vincent P. Corso, Edward W. Cullipher, H. Clinton Davis, Robert F. Dickey, L. Washington Dowlen, Leon S. Eisenman, Franklin J. Evans, Willard L. Fitzgerald, Michael M. Gilbert, Milton S. Goldman, Maurice M. Greenfield, W. Tracy Haverfield, James J. Hutson, Truxton L. Jackson, Christian Keedy, David Kirsh, Carlos G. Llanes, James K. McShane Sr., William T. Mixson Jr., Warren W. Quillian, George W. Robertson III, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Irvin Seaman, Winston K. Shorey, Clifford C. Snyder, William M. Straight, Collins W. Swords Jr., Herbert W. Virgin Jr., Arthur W. Wood Jr. *(Absent—Joseph T. Jana Jr.)*
DESOTO-HARDEE-GLADES—*(Absent—Gordon H. McSwain)*
DUVAL—Frederick H. Bowen, Robert J. Brown, Hugh A. Carithers, Clyde M. Collins, Thomas S. Edwards, Emmet F. Ferguson Jr., Gordon H. Ira, Thomas M. Irwin, Edward Jelks, F. Gordon King, Samuel S. Lombardo, Harry W. Reinstine Jr., Sidney Stillman, G. Dekle Taylor, Ashbel C. Williams

ESCAMBIA—Egbert V. Anderson, P. G. Batson Jr., Luther C. Fisher Jr., George W. Morse, John M. Packard
FRANKLIN-GULF—*(Absent—John W. Hendrix)*
HIGHLANDS—C. Brooks Henderson
HILLSBOROUGH—Samuel H. Adams, C. Frank Chunn, Irving M. Essrig, H. Phillip Hampton, Herbert B. Lott, Eugene B. Maxwell, Madison R. Pope, Wesley W. Wilson *(Absent—Herschel G. Cole, Linus W. Hewit, James A. Winslow Jr.)*
INDIAN RIVER—Erasmus B. Hardee Sr.
JACKSON-CALHOUN—James T. Cook Jr.
LAKE—Frederick C. Andrews *(Absent—C. McK. Tyre)*
LEE-HENDRY—Fred D. Bartleson *(Absent—James L. Bradley)*
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—Nelson H. Kraeft, George S. Palmer *(Absent—Thomas J. Bixler, Hilliard R. Reddick)*
MADISON—*(Absent—Julian M. DuRant)*
MANATEE—Irving E. Hall Jr., John A. Shively
MARION—William H. Anderson Jr. *(Absent—Henry L. Harrell)*
MONROE—Ralph Herz
NASAU—*(Absent—Cecil B. Brewton)*
ORANGE—Frank C. Bone, Louis P. Brady, Chas. J. Collins, Norman F. Coulter, Harry H. Ferran, Louis C. Murray, Charles R. Sias, W. Dean Steward, Miles W. Thomley, Robert E. Zellner
PALM BEACH—Edwin W. Brown, James F. Cooney, V. Marklin Johnson, Walter R. Newbern, Ralph M. Overstreet Jr., Cecil M. Peek, William H. Proctor *(Absent—William H. Everts)*
PASCO-HERNANDO-CITRUS—Gail M. Osterhout
PINELLAS—Charles E. Aucremann, Edward L. Cole Jr., John P. Ferrell, C. Gibson Hooten, William H. Keeler III, Jack A. MaCris, Norval M. Marr Sr., William G. Mason, George H. Schoetker, Robert T. Walker, Walter H. Winchester, Rowland E. Wood *(Absent—Earl R. Fox)*
POLK—Clarence L. Anderson, Newell J. Griffith, Charles Larsen Jr., Arthur J. Moseley Jr. *(Absent—Samuel J. Clark, Marion W. Hester)*
PUTNAM—Claude M. Knight
ST. JOHNS—Reddin Britt
ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus *(Absent—Howard C. McDermid)*
SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Millard B. White
SEMINOLE—Daniel H. Mathers
SUWANNEE - HAMILTON - LAFAYETTE—Hugo F. Sotolongo
TAYLOR—John H. Parker Jr.
VOLUSIA—C. Robert DeArmas, Richard C. Hartsfield *(Absent—John J. Cheleden, Achille A. Monaco)*
WALTON-OKALOOSA-SANTA ROSA—Frederic E. Caldwell *(Absent—Malcolm C. Crotzer)*
WASHINGTON-HOLMES—*(Absent—One delegate, name not submitted)*
COUNCIL ON SPECIALTY MEDICINE—T. Bert Fletcher Jr., J. Basil Hall, Richard S. Hodes, Willard E. Manry Jr., Ivan C. Schmidt, John S. Stewart *(Absent—Fred H. Albee Jr., William C. Blake, Jack H. Bowen, Michael A. DiCosola, Harry M. Edwards, Richard M. Fleming, Samuel G. Hibbs, John B. Miale, Joseph E. O'Malley, Irwin Perlmutter, Don C. Robertson, Donald W. Smith, H. Lawrence Smith, I. Irving Weintraub, Kenneth S. Whitmer)*
STATE OFFICERS—Leo M. Wachtel, S. Carnes Harvard, Clyde O. Anderson, Ralph W. Jack, Samuel M. Day, Joseph S. Stewart, Eugene G. Peek Jr.
AMA DELEGATES—Francis T. Holland, Burns A. Dobbins Jr., Meredith Mallory *(Absent—Reuben B. Chrisman Jr.)*

Dr. Robert C. Piper, Chairman of the Golf Committee, presented the golf trophies. In the tournament which was held at the North Dade Country Club, there were 28 players. The Orlando Loving Cup for low gross score was presented to Dr. Henry H. Bryant III, of Miami. The Duval Loving Cup for low net score was won by Dr. Donald McMahon Jr. of Pensacola.

Gift certificates were awarded for the low net scores to Drs. Donald McMahon Jr., Edson J. Andrews, Herbert B. Lott, Clarence L. Anderson and Nathan Weil Jr., and for low gross scores to Drs. Henry H. Bryant III, Truxton L. Jackson, Roy W. Brown and Arthur W. Wood Jr.

The speaker thanked Dr. Piper on behalf of the Association for his excellent work in running the tournament.

Dr. Day read the following telegrams:

New York, N. Y., May 25, 1961
Francis T. Holland, M.D.
Americana Hotel
Miami Beach, Florida

PLEASE PRESENT THE GREETINGS AND BEST WISHES OF THE WORLD MEDICAL ASSOCIATION AND ITS UNITED STATES COMMITTEE TO THE FLORIDA MEDICAL ASSOCIATION FOR A MOST SUCCESSFUL MEETING THE WORLD MEDICAL ASSOCIATION WHICH IS THE ONLY REPRESENTATIVE THE PRACTICING DOCTORS HAVE ON THE INTERNATIONAL LEVEL IS CONSTANTLY ENDEAVORING TO PROTECT THE STANDARDS OF MEDICAL CARE MEDICAL EDUCATION AND FREEDOM IN THE PRACTICE OF MEDICINE.

Louis H. Bauer, M.D., Secretary General

Valdosta, Georgia, May 25, 1961
Dr. Leo M. Wachtel, President
Florida Medical Association
The Americana Hotel
Miami Beach, Florida

REGRET I AM UNABLE TO ATTEND FLORIDA MEDICAL ASSOCIATION MEETING AS FRATERNAL DELEGATE FROM MEDICAL ASSOCIATION GEORGIA. WISH FOR YOUR FINE ORGANIZATION A SUCCESSFUL AND PROFITABLE MEETING.

F. G. Eldridge, M.D.

The Speaker announced that Dr. Henry L. Harrell, Chairman of Reference Committee No. I, had to leave and that Dr. Thomas M. Irwin would read the report of that Committee.

REPORT OF REFERENCE COMMITTEE No. I

Health and Education

Dr. Thomas M. Irwin: "Mr. Speaker and Members of the House of Delegates: Your Reference Committee gave careful consideration to items referred to it and makes the following report:

"On the report of the Council on Medical Education and Hospitals, we considered each committee report individually.

Council on Medical Education and Hospitals

WALTER J. GLENN JR., *Chairman*

During the past year the Council on Medical Education and Hospitals has directed its attention to those activities of the Association pertaining to medical education in medical schools and hospitals. The following presents a résumé of those matters of significant importance considered by the Committees under the Council with the resulting recommendations:

"The report of the Committee on Medical Schools is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No objections; no discussion, motion carried.

Committee on Medical Schools

EDWARD W. CULLIPHER, *Chairman*

University of Florida College of Medicine.—Following thorough consideration of the directive of the House of Delegates with regard to changing the name of the "J. Hillis Miller Health Center" so as to place proper emphasis on the University of Florida College of Medicine, the Committee is of the opinion that proper emphasis can be obtained by having the stationery of the medical school printed in such a manner that the name "J. Hillis Miller Health Center" will appear as secondary to the "University of Florida College of Medicine," thus obviating the necessity for any change in name. If such change does not result in gaining proper emphasis for the medical school, then the matter is to be referred back to the Committee for further consideration.

Nonavailability of the University of Florida Hospital facilities to qualified physicians was carefully studied and because of a recent directive from the President of the Florida Medical Association requesting that the matter be further explored in an effort to resolve other areas of misunderstanding that have developed between the medical school and private practicing physicians, the Committee recommends that action be deferred at this time. It is planned that a supplemental report will be submitted at a later date covering this matter.

Income of the teaching staff of the medical school was considered with the resulting recommendation that no action be taken at this time. This item is to be covered in a supplemental report to be submitted at a later date.

Increasing infiltration of nonmedical personnel in the field of medical education was thoroughly considered with the resulting action that the following be called to the attention of the Board of Governors of the Association:

There is a national trend in medical education toward higher percentage of nonmedical personnel and toward closed medical staff in teaching hospitals with resulting isolation of students from physicians in the private practice of medicine. Therefore, it is recommended that this trend not be allowed to continue in the medical schools of our state and that the efforts of the Association be exerted to reverse such trend.

It is suggested that this recommendation be called to the attention of the deans of medical schools in Florida.

The Council desires that (1) the delegates of the Florida Medical Association to the American Medical Association be informed that the Council agrees and recognizes that increased infiltration is taking place and that this unfortunate trend should be reversed; and (2) the Association's delegates to the American Medical Association be informed of the Council's action in this regard requesting that they exert their efforts to reverse this unfortunate trend. The Council further requests that reports of developments resulting from actions of these delegates be referred back to the Council for consideration and evaluation. (See report of Delegates to the American Medical Association.)

The teaching program of the University of Florida College of Medicine, because of its significant importance in the education and training of physician personnel, remains under the advisement of the Committee on Medical Schools for the purpose of continuing study and investigation of certain aspects of the teaching program. It is proposed that upon thorough evaluation specific recommendations be submitted in a supplemental report.

"The report of the Committee on Hospitals is approved with the following substitutions and amendments: The Committee recommended deletion of paragraphs two and three, as they are covered by Resolution 61-11, and further that paragraph four, line nine should read, 'unless the usually accepted definition of the relationship of physician and patient is actually established.'

"Mr. Speaker, I move the adoption of this report as amended."

No discussion; no objections, motion carried.

Committee on Hospitals

WALTER J. GLENN JR., *Chairman*

The resolution of the Duval County Medical Society opposing the requirements of the Joint Commission on Accreditation of Hospitals to the effect that "only reports of clinical laboratory work done in laboratories supervised by qualified clinical pathologists should be accepted for hospital in-patients and out-patients" was considered.

The question raised by the Orange County Medical Society with reference to the insistence by the local hospital that an attending physician's name appear on the emergency room record of each patient seen in the emergency room by an intern or resident physician was considered with the resulting recommendation that all Florida hospitals be requested and instructed to refrain from designating a physician as one treating a patient unless the usually accepted definition of the relationship of physician and patient is actually established.

The Council recommends approval of the idea of progressive patient care as presently being implemented and promoted in Florida hospitals.

"The report of the Committee on Physician Placement is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Physician Placement

MELVIN M. SIMMONS, *Chairman*

Inasmuch as the Association has never determined definite policies in regard to the program of physician placement, the Committee, after careful consideration, adopted the following policies:

Materials Used.—The Committee reviewed the various forms and materials used by the physician placement service and approved their continued use.

Office Space Listings.—Should requests for associates be received from physicians, office space listings will be accepted. However, if the request concerns merely vacant office space or "real estate," the listing would not be acceptable from any source and the person requesting the listing should be referred to The Journal of the Florida Medical Association for a classified ad.

Real Estate and Communities.—In cases where physician opening listings are requested in behalf of large community real estate developments, or if the request originates from persons in the community, it will be acceptable. If the request originates from the real estate developers, such listings will be considered only after field investigation by the Association.

Physician Names and Location Lists.—The names of licensed and nonlicensed physicians will be furnished to Association members upon request. The names of licensed physicians only will be furnished to communities upon request. Lists of licensed and nonlicensed physicians seeking placement will be prepared only every six months. Location lists shall be furnished to licensed and nonlicensed physicians.

Approval by County Medical Society.— When requests from communities (or anyone other than physicians) for additional physicians are received, the local mittee is of the opinion that there are definite needs in county medical society shall approve or disapprove of the need. All listings carried on the locations list placed by other than physicians shall be shown as "Approved by_____ County Medical Society." In cases where no action is taken by the local county medical society, field investigation shall be carried out to determine the local conditions.

Sears-Roebuck Foundation.—The physician placement service's policy towards the Sears-Roebuck Foundation Community Medical Assistance Program shall be one of cooperation.

Placement of Negro Physicians in Florida.—The Committee is of the opinion that there are definite needs in many areas and that placing these physicians should be no problem, but should be handled through the county medical societies. It was pointed out that each local society can best determine the need for Negro physicians in its area.

"The report of the Committee on Internships and Residencies is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Internships and Residencies

HUGH A. CARITHERS, *Chairman*

Following a meeting of the Committee on Internships and Residencies held on December 4, 1960, at the Headquarters Building of the Association, the Committee embarked on two projects. The first was to endeavor to ascertain the status of interns and residents training in the hospitals approved for such training. To this end, a questionnaire was submitted and we were gratified to secure 100% returns. This survey, which we expect to have published in detail, revealed that of the 247 approved internships 206 were filled and of the 483 approved residencies 439 were filled. Salary scale emoluments and other data are contained in the survey.

Despite a relatively small percentage of vacancies in internships and residencies, many smaller hospitals were not filling their positions. Over one third of the interns and over one half of the residents are at Jackson Memorial Hospital and at the J. Hillis Miller Health Center.

The other project being developed by the Committee is the compilation of a brochure entitled, "Florida's Medical Climate." In this small folder we intend to point out some of the advantages of postgraduate training within the state and to list approved programs. It is the hope of the Committee to distribute these to senior medical students in the early fall, and to direct some of them to first year interns who may be interested in residencies. Contact has been made with the Florida Hospital Association relative to financing the project. It might be necessary for the Association to grant some financial aid should the project be approved by the Board of Governors.

"The other Recommendations by the Council are approved with the following amendment: That paragraph four of this report be deleted as it is covered by the report of the Committee for Placement of Refugee Physicians.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Other Recommendations by the Council

Liaison Between Organized Medicine and Hospitals.—The Council, being apprised of the importance of having a more active liaison between organized medicine and hospitals in order to keep abreast of the broad aspects of hospital administrative policies which affect the practice of medicine, conveys the following with recommendation to the Board of Governors:

Again it has come to the attention of the Council that the medical profession has been negligent in its responsibilities in the performance of the duties of the Joint Commission on Accreditation of Hospitals and for this reason it is recommended that the Florida Medical Association through its delegates to the American Medical Association encourage and demand a more active part in proper discharge of those duties and responsibilities. In premise to this recommendation, it is noted that:

1. The American Hospital Association has recommended securing full time services of physicians for the various medical departments of hospitals.
2. There has been a definite union of the American Hospital Association and the Blue Cross.
3. There have been many complaints from the medical profession of the activities in accreditation of hospitals.
4. Standardization of hospital procedures is changing rapidly and should be under medical supervision.
5. Many problems of hospital administration could be eased by closer liaison and clarified communications with the medical profession, and lastly,
6. The American Medical Association had no active liaison with the American Hospital Association at the time of its last meeting.

Liaison with Florida Hospital Association.—The Council, having considered the matter of establishing liaison between the Florida Medical Association and the Florida Hospital Association, recommends that the Florida Medical Association establish liaison with the Florida Hospital Association, the purpose being to encourage and develop programs of mutual interest.

The Council Chairman extends his personal appreciation to the Committee Chairmen and those serving on the Committees under the Council for their interest and active participation in the functions of the Council during the past year.

"The report of the Committee for Placement of Refugee Physicians is approved and it is further recommended that representatives of the exiled Cuban physicians be appointed to the proposed committee.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Committee for Placement of Refugee Cuban Physicians

FRANKLIN J. EVANS, *Chairman*

The beginning of the report of the Committee for Placement of Refugee Cuban Physicians must antedate

the establishment of the Committee on November 25, 1960. The plight of the growing number of Cuban refugee physicians and dentists in Miami during the latter part of 1960 has been well documented in the public press and in the Bulletin of the Dade County Medical Association.

A meeting of the Joint Committee was held in Miami on December 14, 1960. Attending the meeting were representatives of the State Board of Health, State Board of Medical Examiners, Florida Hospital Association, U. S. Public Health Service, President Eisenhower's special representative, Dade County Health Department, Dade County Medical Association, Miami Dental Society and the Cuban Emergency Center of Miami.

As a result of this conference, several affirmative steps were taken to secure immediate if temporary employment for refugee medical personnel in positions not requiring a license but related to medicine in some way. Florida hospitals were surveyed to ascertain the number and type of positions available. The Surgeon General of the U. S. Public Health Service was requested to canvass all regional U.S.P.H.S. offices and state health departments for possible employment opportunities. The response to these efforts was gratifying. By late January of this year some 60 or 70 Cuban physicians had been placed throughout the country.

Unfortunately for the activities of this committee, a complicating factor in relocating foreign physicians today is the recently instituted requirement that foreign medical graduates must pass the examination of the Educational Council for Foreign Medical Graduates (ECFMG) before they may be accepted for residency employment in accredited hospitals. With a view toward planning a long range program of education and relocation to go along with the short range emergency effort, and with invaluable assistance from Dr. Robert Boggs of New York, chairman of the National Committee for Resettlement of Foreign Physicians, many of the Cuban physicians were enrolled to take the ECFMG examination held in April. By passing this examination, some may be able to secure licenses in some states. In this connection and with this committee's and Dr. Boggs' encouragement, a refresher course was instituted and conducted at the University of Miami School of Medicine under the direction of Dr. Ralph Jones Jr.

So much emphasis was placed upon the refresher course and the importance of taking the ECFMG examinations that this factor, combined with the change in administration in Washington, mitigated against the further placement of physicians outside the Miami area until after the results of the examinations become known. Nearly 200 requests for Cuban physicians from accredited hospitals all over the country have been held in order that they might be filled later in a more intelligent and scientific manner, with physicians being placed in positions in which they demonstrated the greatest aptitude. The examination results should be known about May 17.

The following basic policy structure and recommendations are suggested for future handling of the resettlement and placement problems:

(1) The establishment of a central committee or "clearing house" for processing all requests for employment of Cuban physicians, this committee to be composed of representatives of the Florida Medical Association Committee for Placement of Refugee Cuban Physicians, the University of Miami School of Medicine Section of Post-Graduate Medical Education, and the National Committee for Resettlement of Foreign Physicians.

(2) A canvass of all Florida hospitals should be undertaken to determine the number of foreign physicians employed and which of these would benefit by a postgraduate course such as that conducted by the University of Miami School of Medicine. This suggestion was offered by Dr. Ralph Jones Jr. with the thought of improving the quality of patient care in the state's hospitals by providing well trained foreign physicians for these institutions. Dr. Jones has offered to bring these physicians to Miami, possibly under some subsidy arrangement, for training. For the purpose of implementing this idea, we would suggest the formation of a committee consisting of representatives of the Florida Medical Association Committee for Placement of Refugee Cuban physicians, the University of Miami School of Medicine Section of Post-Graduate Medical Education and the Florida Hospital Association.

(3) The establishment of a central clearing house for releasing all publicity relative to the above matters. A committee consisting of representatives of the Florida Medical Association Committee for Placement of Refugee Cuban Physicians, the University of Miami School of Medicine Section of Post-Graduate Medical Education and the Dade County Medical Association could be responsible for preparing and releasing all information to the various news media regarding the progress and accomplishments of the programs enumerated above.

"The supplemental report of the Council on Medical Education and Hospitals covering the grievances of certain members of the Alachua County Medical Society against administration of the University of Florida College of Medicine Hospital was approved.

"Mr. Speaker, I move the adoption of this portion of the report."

Dr. Edward Jelks of Duval moved that the above motion be amended by adding the words "certain members of" before the words "Alachua County Medical Society."

Seconded by Dr. Winston Shorey of Dade.

The amendment to the motion carried.

The motion as amended carried.

Supplemental Report of Council on Medical Education and Hospitals

WALTER J. GLENN JR., *Chairman*

The Council on Medical Education and Hospitals met at the Alachua County Health Department at 10:00 a.m. on May 6, 1961. Council members in attendance were Drs. Walter J. Glenn Jr., Chairman, Fort Lauderdale; Hugh A. Carithers, Jacksonville; Melvin M. Simmons, Sarasota; and Edward W. Cullipher, Miami. A majority of the members of the Alachua County Medical Society was present.

The meeting was called at the request of Dr. Wachtel to hear the grievances set forth by certain members of the Alachua County Medical Society directed primarily against the administration of the University of Florida College of Medicine Hospital. The grievances were heard by the Council and Dean Harrell, and members of the medical school faculty were heard in rebuttal.

After careful consideration of the grievances, the Council agrees unanimously that serious problems exist which have not been resolved:

1. The creation of the medical school in Gainesville has resulted in a competition for patients which is reacting to the disadvantage of the physicians in private practice in the Gainesville area.
2. The Council recognizes that the medical school has a problem also, of obtaining adequate teaching material.
3. The Council believes that there are not, under the present system, enough patients in the immediate area to satisfy the needs of the medical school without continued detriment to the private practitioners.
4. Emphasizing some of these problems are grievances concerning referrals, return of patients to referring physicians, publicity from the University, accep-

tance of patients from the emergency room, solicitation of patients and rates charged to patients at the University Hospital.

It is apparent that the Alachua County Medical Society has been unsuccessful in solving these problems, which the Council feels should be solved locally if possible.

The Council, therefore, recommends:

1. That the problems enumerated be referred back to the Alachua County Medical Society, with the request that they be explored fully by the entire membership of the Alachua County Medical Society, its Liaison Committee, and the medical school faculty; and as many of these problems as possible be resolved at the county level.
2. It is further requested that those problems which cannot be resolved at the county level be documented and reported back to this Council within a period of 90 days.
3. It is further recommended that in the future closer liaison be established between the Medical Advisory Committee to the University of Florida College of Medicine and the Liaison Committee of the Alachua County Medical Society.
4. This Council urges more cooperation between the medical school and the county medical society.

"The report of the Scientific Council and its Committee on Scientific Work is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Scientific Council

THAD MOSELEY, *Chairman*

Your Scientific Council for the year 1960-1961 has directed its efforts toward a coordination of Research, Postgraduate Education and utilization of speakers upon the scientific program of the Annual Meeting.

In working toward this end, the Chairman of the Committee on Research has defined research as it applies to the Florida Medical Association; is developing a survey with the cooperation of the State Board of Health to determine the research now being carried on within the state; has formalized an application which may be used by any person or organization seeking funds through the Research Committee; and plans to question each member of the Association regarding his opinion as to research needed within the state. This Committee continues to recognize the fact that it has no power to authorize expenditure of funds, but is an evaluation committee which is willing to accept the responsibility of interim report and final evaluation upon any project which, following approval by the Research Committee, is granted funds through the Board of Governors of the Florida Medical Association or the Florida Medical Foundation.

Your Committee on Postgraduate Education has developed a questionnaire which is now in use for evaluation of programs and speakers who appear within the state. It has established criteria which we believe are adequate for designating approval, sponsorship or cosponsorship. This Committee also recognizes the fact that it has no power to expend funds, but is an evaluating committee whose recommendations are forwarded to the Association's Board of Governors for final decisions as to approval.

The Committee on Publications has functioned smoothly for a long period of time with continued improvement in all state publications. Your Council is of the opinion that this organization should continue the policies which have been in effect, and no suggestions have been made to this Committee by your Council.

Your Committee on Scientific Work has prepared the 1961 program for the Florida Medical Association. This program features the cooperative use of distinguished speakers by the special interest groups and the Florida Medical Association; it continues to expand greatly, through the Florida Chapter of the American Physicians Art Association, the hobby exhibits; and it adds as a new and interesting scientific session two one hour diagnostic clinics which are being prepared by Dr. Franz H. Stewart.

As Chairman of your Council, I wish to thank Dr. James J. Griffitts, Chairman of the Committee on Research; Dr. James L. Borland, Chairman of the Committee on Postgraduate Education; and Dr. Shaler Richardson, Chairman of the Committee on The Journal and Other Publications, for their complete support and full efforts which have enabled us to develop the policies for your Scientific Council in its first year of existence.

Committee on Scientific Work

THAD MOSELEY, *Chairman*

The Committee on Scientific Work, composed of Drs. Thad Moseley, Chairman, John M. Packard, Charles K. Donegan, Richard F. Sinnott, and Franz H. Stewart, has functioned with complete cooperation of each of its members through 1960-1961. At the request of the Board of Governors the meeting dates for the Annual Meeting have been changed to May 25-28, 1961. The first scientific session will be upon Friday morning, May 26, and will be composed of two one hour diagnostic clinics under the direction of Franz H. Stewart, M.D., with the panelists being doctors from over the state who are particularly interested in the subjects to be discussed. The Second Scientific Session will be presented Friday afternoon, May 26, with the speakers being physicians from the state of Florida who will present six original papers. The Third Scientific Session will be held upon Saturday morning, May 27, and for this session speakers have been obtained with the cooperation of the special interest groups as follows:

Florida Academy of General Practice
Dr. Charles A. Owen Jr.
Florida Pediatric Society
Dr. Harold W. Dargeon
Florida Chapter, American College of Surgeons
Dr. Oscar Creech Jr.
Florida Urological Society
Dr. Robert S. Hotchkiss
Florida Society of Anesthesiologists
Dr. John Adriani

As Chairman of your Committee on Scientific Work, I wish to thank you for the privilege of this honor through 1960-1961 and wish to thank each Board member for his whole-hearted cooperation in developing the 1960-1961 program.

"The report of the Committee on The Journal and Other Publications is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on The Journal and Other Publications

SHALER RICHARDSON, *Chairman*

My appreciation is extended to those who through the past year have contributed to the financial and professional success of The Journal of the Florida Medical Association. Volume XLVII, ending with the June issue, had 1,441 pages. A total of 54,105 copies was printed, an increase of 5,480 over the previous volume. Included in the 12 issues were 67 scientific papers and 50 abstracts.

"In connection with the report of the Council on Specialty Medicine, the Reference Committee moves the adoption of this report and wishes to

point out that the meeting was held in conjunction with the Fee Schedule Committee of the Florida Medical Association rather than the Fee Schedule Committee of Blue Shield, as is indicated in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Council on Specialty Medicine

T. BERT FLETCHER JR., *Chairman*

The Council on Specialty Medicine has completed its first year of existence under the new organization of the Florida Medical Association. We had our first organizational meeting at the time of the Florida Medical Association meeting in Jacksonville in 1960, and since then we have had one called meeting during the year. The special meeting of the Council on Specialty Medicine was held on January 15 at the Robert Meyer Hotel in Jacksonville. The meeting was held in conjunction with the Fee Schedule Committee in an effort to review the fee schedule as set by Blue Shield.

Early in the year each specialty group was asked to appoint a committee to make recommendations to the Fee Schedule Committee concerning the fees that would pertain to their specialty groups. This was done by most of the specialty groups, but not all groups participated. At the time of the meeting in Jacksonville we had good representation from all the different specialty groups; most of them were represented by their presidents.

The members of the Fee Schedule Committee gave a very good discussion concerning their desire to obtain and keep up to date a current fee schedule that would be fair to all groups in the field of medicine and also to the insurance holder. The Fee Schedule Committee stressed the importance of the specialty groups taking into serious consideration the importance of logical fee schedules and also pointed out that the fee schedules could not continuously go up.

The representatives of the specialty groups pointed out to the Fee Schedule Committee that the fee schedule still contained many inequalities and that further revision should be done in many areas.

It was the opinion of all those present from both groups that a meeting such as this was very beneficial and that further work should be done along this line, with all the different specialties of medicine represented.

We feel that the Council on Specialty Medicine has an important place in our Medical Association organization; it can keep the different groups organized, and when opinions from the different medical specialty groups are requested, and official opinion can be obtained through the Council.

"Resolution 61-7, Free Choice of Physician and Hospital, by the Duval County Medical Society is approved and we also recommend that a copy of this resolution be sent to Blue Cross of Florida.

"Mr. Speaker, I move the adoption of this resolution."

No discussion; no objections, motion carried.

Resolution 61-7

Free Choice of Physician and Hospital
Duval County Medical Society

WHEREAS doctors and hospitals have assured patients the free choice of physician and hospital as a distinct advantage of voluntary insurance over government medicine; therefore be it

RESOLVED, That the Duval County Medical Society request that hospitals be requested to stop the practice of removing a private patient from the care of a private doctor and placing the patient on the "charity service" because the patient's insurance does not cover the full cost of the cheapest hospital bed and the patient is unable to pay the difference, although the insurance pays the hospital half to full "billing" for most ancillary services; be it further

RESOLVED, That the Duval County Medical Society instruct its delegates to the next regular meeting of the House of Delegates of the Florida Medical Association and of Blue Shield of Florida to present a copy of this resolution to those bodies and seek their endorsement of its principles so that patients throughout Florida can benefit from them, and be it further

RESOLVED, That the Florida Medical Association, if it approves these principles, instruct its delegates to the American Medical Association House of Delegates to seek the endorsement of like principles by that body at its next regular meeting, and be it further

RESOLVED, That a copy of this resolution be sent to the Jacksonville Hospitals Education Program, the Jacksonville Hospital Council, the Florida Medical Association, and the Blue Shield of Florida.

"Resolution 61-8, Service Benefits — Hospitalization, by the Duval County Medical Society is approved as printed in the Handbook, and we further recommend that a copy of this resolution be sent to Blue Cross of Florida.

"Mr. Speaker, I move the adoption of this resolution."

No discussion; no objections, motion carried.

Resolution 61-8

Service Benefits—Hospitalization
Duval County Medical Society

WHEREAS, Blue Shield of Florida, as well as Blue Shield in many other states, has offered service contracts to patients in higher income brackets than those originally planned; and

WHEREAS, Blue Cross of Florida, as well as those in many other states, offers excellent financial coverage for ancillary services in hospitals, but does not offer a reasonably priced contract which will pay "service benefits" for a hospital bed in many hospitals; and

WHEREAS many other private insurance plans likewise pay hospitals generously for ancillary services, but do not assure the patient a hospital bed for their payment; and

WHEREAS the "socializers" are attempting to take advantage of any defect found in voluntary health insurance such as this failure of insurance to guarantee the payment to cover the basic cost of even the cheapest hospital bed in many hospitals; therefore be it

RESOLVED, That the Duval County Medical Society in regular meeting on April 4, 1961, endorse the principles of Blue Shield service benefits for low and moderate income patients, and reasonable fees for private patients whether or not they are covered by insurance; and be it further

RESOLVED, That the Duval County Medical Society request that participating hospitals of Florida Blue Cross make "service benefit" hospital beds available to low and middle income subscribers, and low cost beds available to patients whether or not they are covered by insurance; and be it further

RESOLVED, That the Duval County Medical Society instruct its delegates to the next regular meeting of the House of Delegates of the Florida Medical Association and

of Blue Shield of Florida to present a copy of this resolution to those bodies and seek their endorsement of its principles so that patients throughout Florida can benefit from them; and be it further

RESOLVED, That the Florida Medical Association, if it approves these principles, instruct its delegates to the American Medical Association House of Delegates to seek endorsement of like principles by that body at its next regular meeting; and be it further

RESOLVED, That a copy of this resolution be sent to the Jacksonville Hospital Education Program, the Jacksonville Hospital Council, the Florida Medical Association, and the Blue Shield of Florida.

"Resolution 61-11, Office Laboratory Work, by the Duval County Medical Society is approved in principle as printed in the Handbook.

"Mr. Speaker, I move the adoption of this resolution."

No discussion; no objections, motion carried.

Resolution 61-11

Office Laboratory Work
Duval County Medical Society

WHEREAS fear exists that accreditation will be withdrawn from certain Jacksonville hospitals unless all recommendations of the Joint Commission on Accreditation of Hospitals are fulfilled; and

WHEREAS laboratory work should be considered a part of the practice of medicine; and

WHEREAS competent doctors of medicine other than qualified clinical pathologists can do laboratory work and can adequately supervise the work of technicians; and

WHEREAS duplication of laboratory by hospitals unnecessarily increases the cost of medical care which is already high; and

WHEREAS the assignment of patients to hospital laboratories as outpatients for laboratory work may entail long periods of waiting and increased anxiety; and

WHEREAS the members of the Duval County Medical Society commend the purposes and principles usually proposed by the Joint Commission on Accreditation of Hospitals, but disagree strongly with this particular infringement on the practice of medicine; be it therefore

RESOLVED, That the Duval County Medical Society go on record in opposition to the recommendation of the Joint Commission on Accreditation of Hospitals to the effect that "only reports of clinical laboratory work done in laboratories supervised by qualified clinical pathologists should be accepted for hospital in-patients or out-patients. This should be the original report from the laboratory and properly authenticated, be placed in the patient's record," be it further

RESOLVED, That laboratory work attached to the clinical record by the responsible staff doctor be accepted at its face value; be it further

RESOLVED, That safeguards be established and enforced against violations of the ethics and principles of this privilege; be it further

RESOLVED, That the Joint Commission on Accreditation of Hospitals be informed of these recommendations and be requested to stop this trend toward the removal of authority for the patient care from individual doctors of medicine who have not infringed upon privileges granted them; and be it further

RESOLVED, That a copy of this resolution be sent to the Florida Medical Association with the request that it adopt similar action and instruct its delegates to the American Medical Association to seek the adoption of like action by that body, and be it further

RESOLVED, That copies of this resolution be sent to each state medical association and to each county medical society in the State of Florida, and that they be urged to take similar action to safeguard the practice of medicine by doctors of medicine.

"Resolution 61-12 on General Practice Residencies is approved as printed in the delegates' packets.

"Mr. Speaker, I move the adoption of this resolution."

No discussion; no objections, motion carried.

Resolution 61-12

General Practice Residencies
Volusia County Medical Society

WHEREAS, Many general practice residencies are unfilled and many have inadequate progressive and integrated training programs, and

WHEREAS, the present two year family practice pilot program of the American Medical Association fails to adequately prepare the young physician to do general practice in his own community, and

WHEREAS, each segment of organized medicine has—and still—determines the minute details and over-all content of their respective training programs, therefore be it

RESOLVED, that the Council on Medical Education and Hospitals be directed to formulate other pilot two year progressive training in cooperation with the American Academy of General Practice.

"Resolution 61-13 on General Practice Residencies is disapproved since it is identical with resolution 61-12.

"Mr. Speaker, I move the adoption of this portion of the report."

Dr. Franklin J. Evans of Dade moved that resolution 61-13 be combined with resolution 61-12 rather than being disapproved.

Amendment carried; motion as amended carried.

The same action was applied to Resolution 61-19 on General Practice Residencies, submitted by the St. Lucie-Okeechobee-Martin County Medical Society, since this resolution is also covered by 61-12.

"Resolution 61-18, Designation of Physicians in Emergency Rooms, was disapproved since it is covered in the report of the Committee on Hospitals.

Mr. Speaker, I move the adoption of this portion of the report."

Dr. George W. Morse of Escambia moved that this resolution be considered as being included in the report of the Committee on Hospitals rather than disapproved.

Amendment carried; motion as amended carried.

"Mr. Speaker, I move the adoption of this entire report as amended."

No discussion; no objections, motion carried.

REPORT OF REFERENCE COMMITTEE No. II

Public Policy

Dr. Francis N. Cooke: "Mr. President, Mr. Speaker, and Members of the House of Delegates: Your reference committee gave careful consideration to items referred to it and makes the following report:

"The first four paragraphs of the report of the Council on Allied Professions and Vocations are approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of this report."

No discussion; no objections, motion carried.

Council on Allied Professions and Vocations

W. TRACY HAVERFIELD, *Chairman*

The Council on Allied Professions and Vocations is a new body created in the Association's revised Charter and By-Laws which became effective in April, 1960. Its role is to maintain liaison with and serve in an advisory capacity to all allied and auxiliary professions officially recognized by the Board of Governors.

In its first year of existence, the Council's success in achieving its goals may be described as showing a wide variety of degrees. Due to a necessary difference in approach toward the various individual groups and to past programs in some fields and none in others, it is difficult to measure accurately the Council's over-all progress. It may be stated that while the efforts of several of the Councils committees are encouraging, future emphasis will need to be placed upon establishing active programs by other committees in areas in which these activities have not been carried out previously. It should be emphasized, however, that all of the committee programs are long term in nature and thus the tangible results are often slow in developing.

During the year, the Council held one formal meeting on August 28, 1960, during which Council procedures and policies were adopted and committee programs were discussed and planned. A communication including descriptive information and expressing the wish and willingness to establish closer relations with medicine was received from the Florida Podiatry Association. This is a matter which probably will require official action in the near future.

A summary of committee reports follows.

"The report of the Committee on Dentistry is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Dentistry

J. CHAMPNEYS TAYLOR, *Chairman*

As shown by the letter which follows, the Florida Dental Association was solicited shortly after the meeting of our Council on August 28, 1960. I regret that this letter did not provoke a response.

September 1, 1960

Dr. Wallace Mayo
901 12th Avenue
Pensacola, Florida

Dear Doctor Mayo:

Last Sunday, in the FMA Building here in Jacksonville, the Council on Allied Professions and Vocations, chairmanned by Dr. Tracy Haverfield of Miami, had its first meeting of this fiscal year. As the title implies, this Council concerns itself with interprofessional relations and with those ancillary services more or less intimately associated with the practice of medicine. There are specific committees set up for each as follows: Dentistry, Law, Nursing, Medical Assistants, Physical Therapy, Medical Technicians, Pharmacy, Veterinary Medicine, X-Ray Technicians.

Physicians have apparently considered their relations with dentists of such a high order that neither organized medicine nor organized dentistry in this state has ever had any active program on a state level to promote better relations or to perhaps share certain mutual problems. At our recent meeting, the dentist's role in hospital practice, the responsibility of the medical and dental profession insofar as certain legislative matters are concerned, licensure, and disciplinary actions against practitioners in our respective fields (narcotics misuse, nonlicensed practitioners, etc.), were discussed.

I have been asked to serve as Chairman of the Committee on Dentistry and want you to know that the Council stands ready to cooperate in any way, including participation in joint meetings, if this seems worthwhile.

Sincerely,

JCT:RR
cc: Dr. W. Tracy Haverfield
Dr. Hal Leyland

"The report of the Committee on Law is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Law

W. TRACY HAVERFIELD, *Chairman*

This Committee inherited a program of liaison which has existed for the past several years with The Florida Bar. The principal activity of this program has been the joint sponsorship of a series of medicolegal institutes for the medical and legal professions. Although there have been no institutes held as of this writing since April 1960, the Committee is planning future programs aimed more directly toward practicing physicians and emphasizing subjects not hitherto covered in previous institutes. The Committee continues to be concerned with placing greater emphasis on the teaching of medical jurisprudence in medical education and with encouraging the establishment of a uniform medicolegal examiners system in Florida.

"The report of the Committee on Medical Secretaries and Assistants is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Medical Secretaries and Assistants

ENSOR R. DUNSFORD JR., *Chairman*

On March 19, 1960, a meeting called by The Florida Medical Assistants Association was attended, and representatives of the Florida State Board of Health, Florida Nurses Association, Florida Society of Medical Technologist, University of Tampa, Vocational Rehabilitation and

University of Florida were also present. The plan was to make statewide educational facilities available to its members, and the subjects to be covered were outlined. It was mentioned that laboratory procedures would not be covered, except for teaching terminology to help interpret such studies.

On June 4, 1960, during The Florida Medical Assistants Association Convention in Jacksonville this Committee was furnished copies of the syllabi for the three initial courses to be offered under the educational program of this group.

On June 12, 1960, the Board of Governors of the Florida Medical Association approved the program for a period of one year and requested that it be brought back to the Board for further recommendations.

On August 28, 1960, the Council on Allied Professions and Vocations of the Florida Medical Association met and endorsed the educational program of The Florida Medical Assistants Association.

I have recently received a letter from The Florida Medical Assistants Association asking for approval for a course in "Anatomy and Physiology" and one in "Medical Terminology" beginning in September 1961.

"On the report of the Committee on Medical Technicians, the Committee recommends that paragraph 4 on page 30 be deleted and paragraph 5 be amended to read: 'Recommendations: It is urged that the Florida Medical Association maintain continued close liaison with the technicians and technologists of Florida. The American Society of Medical Technologists has traditionally worked in close harmony with pathologists, with other physicians, and with hospitals. It is urged that talks be continued between members of our Association and these groups.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Committee on Medical Technicians

C. MERRILL WHORTON, *Chairman*

At the recommendation of the Council, liaison was established between the Florida Medical Association and the Florida Society of Medical Technologists and the Florida Division of the American Society of Medical Technologists, two large organizations of technologists and technicians in this state. This was effected by a letter to the presidents of these organizations from the President of the Florida Medical Association, Dr. Leo M. Wachtel.

Your Committee Chairman was asked to investigate a course in "Medical Technology" in a local high school. It was feared that students taking this course might assume unwarranted competence in this field and might seek employment as trained technicians. On the contrary, this course seems to be a good introduction to certain practical aspects of biology. It might assist in recruiting students in the field of medical technology.

From October 14 through October 16, the Committee Chairman attended a joint meeting of the American Society of Medical Technologists, Florida Division, and the Florida Society of Medical Technologists at Sarasota. A forum on licensure was held, and forum speakers representing the technologists and technicians favored revision of the state law regulating the practice of Medical Technology and providing for licensure of workers in this field. Dr. Millard B. White, a pathologist, spoke in opposition to changing the present law as did a hospital administrator who unofficially represented the Florida Hospital Association. It is the consensus that most members of the Florida Society of Medical Technologists are in favor of changing the present state law regarding licensure of technologists and technicians. At a business meeting of the Florida Division of the American Society of Medical Technologists the membership voted in favor of "adequate legislation." The majority of the members present agreed that the existing bill was inadequate chiefly because all laboratory workers were not examined and licensed. (Hospital, office and government-employed technicians are exempt under the law now in effect.)

Since this time a legislation committee of the Florida Division of the American Society of Medical Technologists has been appointed to study state licensure, make inquiries of interested medical organizations, meet with members of the Florida Society of Medical Technologists and the Florida Hospital Association, and draw up in rough form a bill to be presented to the next meeting of the Florida legislature in 1963.

On January 21, 1961, the Chairman of this Committee sent representatives to the Board of Directors meeting of the Florida Division of the American Society of Medical Technologists in Orlando. It would appear that this technologist organization would recommend a very stringent state law of licensure which would require any person performing laboratory tests in this state to pass an examination and be licensed in several categories depending on qualification. There would be three categories as follows: (1) Licensed Laboratory Directors, (2) Licensed Medical Technologists, (3) Licensed Laboratory Assistants. All laboratory workers, including those in physicians' offices, in hospitals and in governmental laboratories would be required to obtain a license.

During the year there has been considerable correspondence between Mr. Leslie Lee, President of the Florida Division of the American Society of Medical Technologists, and Dr. Leo M. Wachtel, President of the Florida Medical Association. In February 1961, Mr. Lee came to Jacksonville for discussion on this subject. He seems to be a very reasonable person, and is anxious to maintain close liaison and harmony with the pathologists and other physicians of this state.

In November 1960, Dr. Wachtel, as President of the Florida Medical Association, received a communication from the American Society of Professional Biologists Incorporated agitating for governmental licensure of technicians and technologists and related workers. The Chairman of the Committee on Medical Technicians of the Florida Medical Association sent a copy of this communication to the president-elect of the American Medical Association, Dr. Leonard W. Larson. Dr. Larson in his reply referred to the report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Vocations of the American Medical Association, the so-called McKeown Committee Report, dated June 16, 1960. It is felt that the American Society of Professional Biologists Incorporated has distorted the recommendations of the McKeown Committee, which indorsed voluntary regulation for nonmedical groups in the health field. Although the McKeown Committee did not take a permanent rigid position on licensure, it stated that if licensure is indicated, the indication must be mutually agreed on as being in the public interest and must be jointly developed by the segments of medicine concerned, medicine itself and the nonmedical groups seeking licensure.

Recommendations: It is urged that the Florida Medical Association maintain continued close liaison with the technicians and technologists of Florida. The American Society of Medical Technologists has traditionally worked in close harmony with pathologists, with other physicians, and with hospitals. It is urged that talks be continued between members of our Association and these groups.

"On the report of the Committee on Nursing, we recommend the following addition: In order to encourage an increase in various nurse diploma

programs conducted by hospitals, the Committee recommends a review of naional and state nursing educational requirements, in regard to prolonged absence of in-training nurses to fulfill present requirements of nursing educational programs. Such policies have placed unnecessary economic burdens on participating hospitals.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Committee on Nursing

THOMAS C. KENASTON SR., *Chairman*

The activities of your Committee on Nursing have been largely through our representation of the Florida Medical Association on Advisory Committees to the State Department of Education, on the State Advisory Committee for Practical Nursing Education, and through the same representation on the Advisory Committee for the Project for the Improvement of Nursing Education and Nursing Service in Florida, with special emphasis on the Junior Colleges (the W. K. Kellogg Grant). These programs are well developed and show a great deal of promise toward alleviating the chronic shortage of nurses which exists in all categories.

Your Chairman is also meeting with the Committee on Legislation of the Florida Nurses Association to assist it wherever possible with desirable legislation to be presented at the current session of the state legislature.

We view with some concern the impact, whatever it may be, of the legislation in the Congress for the Care of the Aged. Regardless of what measure may eventually be forthcoming, the utilization of nursing care should be much greater, and we are at a loss to know from where the supply of nurses will eventually come. There are currently four programs of Nursing Education in the state.

They consist of (1) the Bachelor Degree Programs conducted at the Florida State University, the University of Florida, and the University of Miami; (2) the various Diploma Programs conducted by hospitals; (3) the Associate Degree Programs getting under way in our Junior Colleges; and (4) the Practical Nurse Programs.

We believe that the Associate Degree Programs developing in the Junior Colleges show the most promise of providing additional well trained nursing personnel for the care of the sick. We recognize the great contributions that the Hospital Diploma Schools have made and are continuing to make in providing well trained nurses, and we also recognize the increasing difficulties that the hospitals are having in maintaining these programs. We would like to urge every member of our Association to give any assistance he can to these hospitals that are continuing their programs, to the establishing of additional Hospital Nursing Schools where it is possible, and to the reactivation of schools that have had to be closed.

In order to encourage an increase in various nurse diploma programs conducted by hospitals, the Committee recommends a review of national and state nursing educational requirements, in regard to prolonged absence of in-training nurses to fulfill present requirements of nursing educational programs. Such policies have placed unnecessary economic burdens on participating hospitals.

"The report of the Committee on Physical Therapy is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Physical Therapy

ROBERT P. KEISER, *Chairman*

During the past year the Committee on Physical Therapy has maintained a close liaison with the officers and various committee chairmen of the Florida Chapter of the American Physical Therapy Association. We have assisted and advised them in several matters of joint interest which fell within our province and capability of so doing.

One of the primary problems at the time this report is being submitted revolves around a proposed attempt by the osteopaths in the state to amend the Physical Therapy Practice Act now in force to stipulate in so many words that a "Registered Physical Therapist" may practice under the direction and supervision of an osteopath. It is the opinion of this Committee and the physical therapists that such an amendment is superfluous since there is nothing in the Law, as it now reads, to prevent physical therapists from practicing under the direction of an osteopath. In addition, the "national organization of the American Physical Therapy Association has submitted an opinion that there is nothing in its code of ethics which prevents a physical therapist from accepting orders from an osteopath although it discourages the practice. The decision was therefore reached and recommendation made to the Committee on State Legislation of the Florida Medical Association that any attempt to amend the present Physical Therapy Act in such manner be opposed in the legislature.

It is the considered opinion of this Committee that the Florida Chapter of the American Physical Therapy Associaion has improved its organization from within and as a group is making a sincere effort to maintain and improve high standards of practice in its profession and is desirous of seeking the cooperation and advice of the medical profession to realize these goals.

"The report of the Council on Voluntary Health Agencies is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Voluntary Health Agencies

MASON ROMAINE III, *Chairman*

The Council on Voluntary Health Agencies was created as a new structure under the Association's revised Charter and By-Laws which took effect in April 1960. Because of the necessary time involved in evaluating voluntary health agencies applying for recognition, the Council was not officially activated until January 15, 1961, at which time the Board of Governors granted recognition to three of the four agencies initially evaluated. Subsequently, in accordance with the By-Laws, the President appointed, in consultation with each agency, the required three physicians as members of the Council. With the designation of one of these physicians as Council Chairman, the Council was then in a position to assume from the Board of Governors its responsibility in carrying out evaluation of additional agencies requesting recognition.

The first three recognized agencies are the Florida Division, American Cancer Society; Florida Chapter, Arthritis and Rheumatism Foundation, and Florida Heart Association. Action was deferred on another agency requesting recognition pending receipt of additional information. Following activation of the Council, three other agencies have applied for official recognition. These agencies are the Florida Association for Mental Health, Florida Society for Crippled Children and Adults, and

Florida Tuberculosis and Health Association. After careful consideration of the information supplied by these agencies relative to the Association's criteria, it is the recommendation of the Council that these three agencies be granted official recognition and thereby positions on the Council.

Because the Association's program of liaison with voluntary health agencies is in an early organizational state of development, it is impossible to report specific progress as of this writing. The magnitude and complexity of developing criteria for recognition, initiating contacts with statewide agencies, and evaluating sometimes voluminous materials submitted by the agencies, may easily be appreciated. The Council is grateful to the officers and Board of Governors for their invaluable assistance in accomplishing these necessary early steps in the program. We look forward to an increasingly active implementation of the Council's program in the year ahead.

"The first portion of the report of the Council on Medical Services, which is the report of the Chairman, is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Medical Services

MARION W. HESTER, *Chairman*

The Council on Medical Services met at the Florida Medical Association headquarters in Jacksonville on May 22, 1960, with seven of the Council's 12 members in attendance.

The following matters were accomplished:

1. Policies and procedures were adopted for the functioning of the various Committees within the Council's framework and of the Council within the Association's structure in implementation of the Association's By-Laws.

2. Past and present activities of the individual Committees were reviewed and evaluated and committee programs for the year were approved and adopted.

During the year most of this Council's 12 Committees have carried out an active program. Much of this work has followed a pattern set by former committees but in addition many new courses of action have been chartered. On the whole, Committees have applied themselves and much that is good has been accomplished.

A committee such as the Committee on Blood has had little reason to be active this year, but a new year may bring need for more activity. In the event of a major disaster or war this Committee would necessarily be a busy one.

The Committee on Labor, a new committee, has no precedent to serve as a guide in promotion of a committee program. It is hoped that this Committee will actively apply itself to the medical-labor field and develop a worthwhile program in the year ahead.

The Committee on Indigent Care does not have as many problems as a like committee in some of the states with more economic problems than in our state. Even in Florida there is still fertile ground for work in this field. It is recommended that this Committee consider the problems concerned and develop a constructive program of committee work in indigent care.

"The committee recommends that the last paragraph of the report of the Committee on Aging be deleted. This seems to be a function of other Committees and is being studied at other levels.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Committee on Aging

LOUIS L. AMATO, *Chairman*

The following is a brief summary of the activities of this Committee:

Held meetings on May 28, July 28 and October 20, 1960, and March 30, 1961.

Attended the American Medical Association regional meeting in Atlanta for the White House Conference on Aging.

Attended the American Medical Association headquarters meeting on Aging in Chicago.

Attended the White House Conference on Aging in Washington.

Spearheaded the formation of the Florida Joint Council to Improve the Health Care of the Aged, the Committee acting as the sponsoring agency.

At its meeting of July 28, 1960, the Committee proposed the following activities.

The formation of the Florida Joint Council to Improve the Health Care of the Aged, with this Committee acting as host.

Following the formation of the Florida Joint Council, efforts will be made through it to establish similar councils at the county level. This is desirable since any programs of community action will necessarily require the combined efforts of all the member agencies.

Make a greater effort to have every county medical association appoint a local Committee on Aging.

Request the program committee of every county medical association to (1) sponsor a Scientific Program on Geriatrics for one of the regular meetings, and (2) sponsor the planning and the presentation of a program on Gerontology, to be given with the combined support of all the member agencies of the Joint Council, for community participation.

Encourage the formation of Speaker Groups on Geriatrics.

Have available teams of Geriatrics—interested physicians who may monitor or serve on panels for Forums on Geriatrics, both for professional and lay groups.

"The report of the Committee on Blood is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Blood

V. MARKLIN JOHNSON, *Chairman*

To date no problems concerning this Committee have been directed to the attention of the Chairman. The Committee may be called upon to function in the near future in regard to the inroads of commercial blood banks into the field of blood banking in Florida.

"On the report of the Committee on Cancer, we recommend the amendment of section (a) on page 35 to read: Correctable cancer be specifically included as 'an acute disease' for the purpose of diagnosis and hospitalization. We further recommend the amendment of section (b) on page 35 to read: Bills now pending on cancer

cases rejected by the Welfare Department be reviewed.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Dr. H. Phillip Hampton and Dr. Ashbel C. Williams both spoke against the first amendment offered by the Reference Committee, which inserted the word "correctable" in item (a).

By voice vote, the first amendment of the Reference Committee was lost.

There were no objections to the second amendment and it was carried.

Committee on Cancer

ROBERT F. DICKEY, *Chairman*

There was a meeting of the Florida Cancer Council at Fort Lauderdale on October 8, 1960. The establishment of a tumor clinic was approved at the White-Wilson Clinic in Fort Walton. It was recommended that the clinic be moved to the Fort Walton Beach Hospital when facilities were available and adequate.

It was also approved that expansion of Cervical Cytology be extendedto medically indigent patients attending prenatal and postnatal clinics already set up within the Health Department, arrangements with local pathologists to be made to process the slides.

A consideration of the proposed Anti-Quackery Cancer Law was made. Some revisions were suggested so as to make the wording of the law more specific and to conform with similar laws of other states.

A lengthy discussion was held regarding the recent rejection of many cancer cases by the State Welfare Department for hospitalization payments under the Public Assistance Program for Hospitalization that is derived for state-federal funds upon the questioning of whether the cancer cases were of acute nature. It was recommended that a letter be written to the Attorney General of the State of Florida requesting that:

(a) Cancer be specifically included as "an acute disease" for the purpose of diagnosis and hospitalization.

(b) Bills now pending on cancer cases rejected by the Welfare Department be reviewed, and

(c) The present policy of processing patients through tumor clinics be continued in accordance with the policies as set forth by the Florida Medical Association and the Florida State Board of Health.

It might be added here that the indigent cancer cases have been hospitalized and paid for by state funds since 1947.

In 1946 the first cancer law was passed, so that indigent persons suffering from cancer could be cared for. Our State Law 381.381 of 1955 still remains a part of our statutes. This law was passed in 1955, agreeing that all indigent persons suffering from cancer should be eligible and the special Hospitalization of Cancer Program and the Hospitalization of the Indigent Program should be merged.

In 1959, the Public Assistance Recipients Program, using state funds and matching federal funds, was set up for welfare recipients. It was taken for granted that cancer patients were still to be considered acutely ill requiring hospitalization and the hospital be renumerated.

It was moved by the Advisory Committee for Hospital Service for the Indigent of the State Board of Health and the Medical Advisory Committee of the State Welfare Department on August 7, 1960, that these advisory groups go on record reaffirming the eligibility of the cancer patients for treatment under the Public Assistance Recipients Program, and that cancer should be written into the definition of "acutely ill."

Since August 1960, until February 1961, 134 out of 367 cases of cancer have been rejected by the Welfare Department in spite of being screened by the tumor clinic directors, then by the Florida State Board of Health, and lastly by the State Welfare Department. Of course the hospitals did not refuse treatment, nor was treatment refused by the physicians. However, as of February 1, 1961, there is $22,975.00 due the hospitals of the state. The reason for rejection is under the written notation on the charts: "Is this an acute condition?"

This alarming state of affairs is not rectified as of the date of this report of March 1961.

A meeting of the Florida Cancer Council was held in Tampa, December 20, 1960:

(a) A report of the Fort Walton Beach Tumor Clinic was heard.

(b) A report of the Community Cancer Cytology Program of Dade County was given. Seventeen cases of carcinoma of the cervix have been found to date and referred for treatment. The program is being extended into other counties of the southern part of the state.

(c) A report of the medically indigent women of the postpartum clinics of the county health departments was given.

(d) It was decided that the Anti-Quackery Bill be presented to the state legislature by the American Cancer Society, Florida Division.

(e) It was moved that a bill for state appropriation of hospitalization of cancer cases, for diagnosis and treatment, be presented to the state legislature; that the present state of affairs of hospitalization of cancer patients be brought to the attention of the Head of the State, and that all cancer patients be included in the definition of a medically indigent person who is considered acutely ill or injured.

There has been no meeting of the Cancer Council with the Head of the State or any of his representatives up to the time of this report.

"The report of the Committee on Child Health is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Child Health

WARREN W. QUILLIAN, *Chairman*

During the past year a great deal of effort has been expended in our role as a medical advisory committee to the State Department of Education and to the State Board of Health. Specifically, joint meetings with these groups have been held, and we have been represented at a number of conferences designed for the formulation of policy pertaining to the betterment of the health of school children in Florida. Physicians of the state have been urged to acquaint themselves with needs in their own communities through the establishment of school health committees, and with advisory committees on school health in counties where none exist. Attempts have been made to implement the program for uniform standards realistically.

Seminars and panel discussions on school health problems included a meeting at the University of Florida (Gainesville) with the County Superintendents of Public Instruction in September 1960. A whole day was set aside for informal discussion of mutual problems and points of interest related to improvement of public school health programs throughout the state. Familiarity with the facilities and resouces provided by the Florida Medical Association was stressed. This program was so well received that a similar session is now being planned for the school Principals.

One of our great objectives is to emphasize the importance of the practicing physician in the planning and administration of all school health policies. There has been considerable variation in quality and quantity of school health services among privately operated primary and secondary schools not coming under the jurisdiction

of the state school health program. The recent heavy influx of Cuban refugees to certain sections of Florida has had serious impact especially on parochial schools. The two state agencies provide services to parochial schools only in time of epidemic or when called upon for assistance. The Medical Advisory Committee has advised Gov. Farris Bryant of its concern in this connection. He has promised attention toward helping to solve the pressing problems which exist in some areas.

A joint study committee has been formed, including representatives of the State Board of Health, the State Department of Education, and the Florida Medical Association to work with us in evaluation of Florida laws affecting immunization, and to make suitable recommendations for new legislation or regulations in this field. Members of our Committee on Child Health are serving as representatives of the Florida Medical Association on the Coordinating Committee to follow up the White House Conference on Children and Youth, and to work with the Florida Children's Commission in these matters.

Your Committee will be represented at the American Medical Association Conference on Physicians and Schools at Chicago, March 9-11, 1961. A report of this important meeting will be presented to the Board of Governors at its April session.

In cooperation with the Bureau of Maternal and Child Health your Committee participated in the Postgraduate Obstetric-Pediatric Seminar at Daytona Beach in August 1960. This meeting was well attended by physicians from Florida, Georgia, Alabama, Tennessee and the Carolinas. Two seminars on the care of premature infants have been held during the year at Jackson Memorial Premature Center (Miami), with a member of the Child Health Committee serving as one of the faculty.

Increased publicity through the media of newspapers, "Briefs" (official Association news sheet), and radio and television spot announcements has been designed to keep individual Association members better informed concerning the work of the Committee to encourage immunization and physical examinations for children by their family or personal physicians. Evaluation of textbooks and health instruction methods used in Florida schools will be reviewed by the Committee whenever requested by the two state agencies. It has been pointed out that

This summary records some highlights of our efforts being carried out county-wide in Palm Beach County. during the year. We have in this state an outstanding school health program. Two resolutions adopted by the House of Delegates at the 1960 session have now become a part of our official policy in dealing with problems which arise. These suggest that county school boards consult with local medical authorities before action concerning health-related problems within their public schools, and that members of the Association recognize their own responsibilities in this connection by formation of Advisory Committees on School Health within the county medical society. A successful program depends upon the active interest and leadership of the physicians of the state. Better school health will result only from the cooperative efforts of many community groups and state organizations.

"The report of the Committee on Conservation of Vision is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Conservation of Vision

MARION W. HESTER, *Chairman*

The Committee is continuing its program of attempting to install a uniform, medically supervised program of eye screening in all the elementary schools of the state of Florida.

Progress is being made in this field. The original pilot program continues in Polk County in all the schools of the county. A very good program of the same type is some of the books are outdated or may not be medically Similar programs are being followed in St. Lucie, Okeechobee, and Martin counties. All these programs are using the Atlantic City Test following recommendations of this Committee. Collier County school children are being screened with the Massachusetts Test. Lee County and Hillsborough County school children are being screened with illuminated Snellen charts. All the foregoing programs are being carried out by the County Health Officers with program supervision by a local ophthalmologist. Many other counties have eye screening programs of varying degrees of completeness.

To encourage adoption of the Committee program of eye screening, instruction material has again been mailed from Florida Medical Association Headquarters and the State Board of Health Headquarters to presidents and secretaries of all county medical societies and to all county health officers. This consisted of a memorandum summarizing Committee recommendations on eye screening and offering help and advice in setting up local programs. Included with this memorandum were Committee summaries "Selection of Eye Screening Apparatus For Use in Schools" and instruction sheets "Use of the Atlantic City Test."

The Chairman of this Committee attended a meeting of the Association Committee on Child Health in Jacksonville, November 13, 1960.

The Chairman of this Committee was guest speaker at a Vision Screening Workshop in the Second Annual Conference of the Florida Society for the Prevention of Blindness in Tampa, March 11, 1961.

Recommendations of this Committee for establishing glaucoma detection programs by mass public screening tests were adopted by the Florida Medical Association House of Delegates in 1960. These recommendations were subsequently published in The Journal of the Florida Medical Association. Since then such programs have been held in several areas of the state following these recommendations.

The Committee hopes to gain wider acceptance of the school eye screening program and the glaucoma detection program during the ensuing year.

"The report of the Committee on Emergency Medical Service is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Emergency Medical Service

CORREN P. YOUMANS, *Chairman*

Under this heading comes the old "Committee on Advisory to Selective Service for Physicians and Allied Specialists" and the "Committee on Civil Defense and Disaster."

Under the "Committee on Advisory to Selective Service for Physicians and Allied Specialists," the following report is given: For the past year there have been very few duties for this group as there has been no need for selective service. There have been enough doctors volunteering to fill the quotas. However, as the supply of doctors for selective service has been dropping off this year on a volunteer basis, the duties of this Committee may be increased during the coming year.

Next, we have the report on the portion which deals with Civil Defense and Disaster. During the past year we have had one major disaster, Hurricane Donna, September 9, 10 and 11, 1960, which began on the lower tip of the Florida peninsular and passed up the West Coast to Lakeland, and then diagonally across the state to the Northeast Coast of Florida. The Medical Personnel of

the State of Florida stood ready to give assistance as it was needed, but only a few casualties occurred and therefore Medical Personnel did little work of an emergency nature. As the storm passed through each county, the group of doctors of that area were ready to give assistance. The Medical Personnel works in close cooperation with Civil Defense Organizations through rendering emergency medical service. The medical groups were in close contact with the Civil Defense Organizations so that as emergency care was needed, doctors could be sent to this area.

The duty of the Committee on Emergency Medical Care is to have a direct connection with the Civil Defense Organization and to supply the Civil Defense Organization with the necessary medical groups that may be needed to take care of the emergencies as they arise. Coordination of these two departments is very important and will make for an efficient organization.

The different conventions and schools for Civil Defense that have been established in the United States are meeting a great need in keeping abreast of disaster dangers and how to meet the emergencies.

The Chairman of the Committee on Emergency Medical Service of the Florida Medical Association attended a meeting of the Civil Defense Organization in Minneapolis, Minn., on September 21 and 22, 1960. At this meeting one could clearly see the need for immediate action in training for Civil Defense if we are prepared to meet the emergencies.

"The report of the Committee on Indigent Care is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Indigent Care

ROBERT L. TOLLE, *Chairman*

No major activities have transpired other than the suggestions made in Jacksonville that the studies and recommendations as outlined by the Citizens Medical Committee on Health were exhaustive and practical. They include the recommendations for indigent care as outlined therein.

"The report of the Committee on Maternal Welfare is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Maternal Welfare

JAMES M. INGRAM, *Chairman*

The Committee on Maternal Welfare has undertaken three major objectives during 1960:

(1) Presentation of the Tenth Annual Postgraduate Obstetric-Pediatric Seminar.
(2) Establishment of Florida's first Maternal Mortality Survey.
(3) Survey of the laws of other states relating to the the practice of obstetrics and gynecology.

The Tenth Annual Postgraduate Obstetric-Pediatric Seminar was held at Ellinor Village, Daytona Beach, on August 18-20, 1960. A panel of outstanding speakers was presented. The registration of 383 was among the largest recorded. At the request of the general practitioners, the subject matter was presented at the level of a specialty meeting. The sessions began early and ended at 1:00 p.m., leaving the afternoons for the registrants to spend with their families. Both of these changes were well received. By common consent, the 1961 Seminar will be held for the first time on the West Coast, at the Colonial Inn, St. Petersburg Beach, August 17-19, 1961. An excellent faculty has already accepted invitations. The Board of Health of each of the Southeastern states has continued to give excellent cooperation in presenting the Seminar.

The 1960 House of Delegates authorized the Maternal Welfare Committee to begin the first Maternal Mortality Survey. A study was made by the Committee of the methods of all of the states conducting such a survey. Questionnaires, code sheets, and procedures were developed and standardized. Physicians in the state are now being informed of the start of the survey through The Journal and through Briefs. The profession and lay population will be further informed by news releases to periodicals and newspapers in the near future. The first survey will include all maternal deaths beginning January 1, 1961. Files of the survey will be kept at the Association's office in Jacksonville.

With the aid of the Legal Department of the American Medical Association, this Committee began a study of the laws of other states relating to sterilization, interruption of pregnancy for maternal as well as fetal indication, artificial insemination, and privileged communication. When this study is completed, the Committee hopes to make recommendations for additions to and improvement of existing laws in Florida. These recommendations will be presented to the Committee on State Legislation for its study and then proposal to the legislature.

The maternal death rate in Florida in 1960 was 4.6 per 10,000. The national maternal death rate is 4.5 per 10,000. The death rate in Florida in the previous year, 1959, was 5.5 per 10,000 live births. In 1960 the white mortality rate changed from 2.4 to 1.8 and the colored rate from 14.0 to 12.2. The major effort at control must still be aimed at lowering the colored maternal mortality.

This Committee expresses its gratitude for invaluable aid given by the commercial sponsors of the Seminar, by the health officers of the various Southeastern states, by Dr. Wilson T. Sowder, Dr. Lorenzo L. Parks, Mrs. Alma Lee Cochley, and Mr. Eugene L. Nixon.

"On the report of the Committee on Mental Health, it is recommended that Item 7, page 41, be amended to read: " . . . Following study of this matter, the Committee recommends that the Florida Medical Association oppose the development of ambulatory treatment plans for narcotic addicts and that the delegates to the American Medical Association be instructed to oppose such plans.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Committee on Mental Health

WILLIAM M. C. WILHOIT, *Chairman*

As of this writing, the Committee has held three official meetings during the past year: October 16 and November 20, 1960, and February 26, 1961. On November 20, the annual conference for state mental health leaders was held and on March 11, 1961, the first statewide mental health conference for county society and Woman's Auxiliary representatives was held. The latter two conferences were planned and sponsored by the Committee. In addition, the Chairman and a member of the Committee (Dr. Russ) attended the American Medical Association's Seventh Annual Conference of Mental Health Representatives which was held in Chicago January 20-21, 1961. This conference was highly beneficial.

The following is a partial list of significant matters acted upon, accomplished, or in the process of completion or development by the Committee:

(1) The annual conference for state mental health leaders referred to was attended by some 20 invited key

persons representing the Florida legislature, state agencies and institutions, and voluntary groups. This session represents the only forum wherein these varied individuals and groups can meet together informally to discuss common problems and programs. Because of its lasting benefits to the people of Florida and to our profession, we recommend that these conferences be continued.

(2) It is gratifying to report that many of the recommendations made by the Committee in last year's annual report which had resulted from field liaison visits to the state mental hospitals have either been acted upon or are under consideration by the organizations concerned.

(3) There is reason to believe that the outlook concerning the perennial problem of sexual psychopathy is no longer so dim. The Committee's Chairman-designate has been requested to represent the Committee in encouraging the formation of an interdisciplinary group within the state to explore, study and prepare recommendations with regard to the entire problem of sexual psychopathy.

(4) During the year, the Association's mental health program was reviewed and evaluated by the Committee and certain minor changes made with a view toward keeping its status active and current.

(5) In order to provide further implementation of the Association's mental health program on the county level and to enable county medical societies to exchange program ideas and information, a statewide mental health conference for county medical society and Woman's Auxiliary representatives was held in Jacksonville on March 11, 1961, as mentioned earlier in this report. Dr. Peter F. Regan, professor and head of the department of psychiatry of the University of Florida College of Medicine, served as keynote speaker. As this writing is prior to the conference date, it is not possible to include an evaluation of this initial venture in this report.

(6) A resolution concerning involuntary hospitalization for mental cases presented by the Volusia County Medical Society, which was referred to the Committee by the 1960 House of Delegates, was reviewed in detail by the Committee. The Committee's recommendations in regard to this resolution are appended to this report.

(7) A proposed resolution opposing ambulatory treatment plans for narcotic addiction which was presented by the Federal Bureau of Narcotics was referred to the Committee by the Association's President for review and recommendations. Following study of this matter, the Committee recommends that the Florida Medical Association oppose the development of ambulatory treatment plans for narcotic addicts and that the delegates to the American Medical Association be instructed to oppose such plans.

(8) In its deliberations during the year, the Committee noted the lack of and need for a concise publication for practicing physicians describing state mental health institutions and facilities and explaining admission procedures. It was the Committee's opinion that the average physician is inadequately acquainted with such information relative to the handling of mental patients. After taking up this matter with the various state agencies involved, we can report that all possible means are being explored to accomplish the preparation and distribution of such a publication.

(9) This year the Committee voted to extend its program of field liaison visits initiated last year with the state mental hospitals to the state child training institutions. These visits by Committee members were accomplished during the first three months of 1961 to the Sunland Training Centers at Gainesville, Orlando and in Lee County, and to the Florida School for Boys at Marianna and Okeechobee and the Florida School for Girls at Ocala and Forest Hill. As a result of these visits, the Committee would like to make the following observations and recommendations:

(a) We feel that all of these institutions should be highly commended for the excellent job they are doing under difficult circumstances within their limited budgets. Since physical facilities for the most part are adequate, we recommend that all possible support be given to emphasizing and increasing funds appropriated for adding and upgrading personnel rather than for "bricks and mortar" purposes.

(b) In the planning of future facilities, the Committee endorses the "survey team" approach to assure that such institutions are located properly with all factors considered.

(c) Because of the wide medical, educational and penal functions of the institutions composing the State Division of Child Training Schools, it is the Committee's observation that this agency is faced with an unusual number of top level organizational problems stemming largely from its varied role. Particularly noticeable are cumbersome legislative restrictions which prevent much-needed cooperation, assistance and referral to and from other state agencies, most particularly the Division of Mental Health, the state universities (University of Florida College of Medicine), the Division of Corrections and the State Board of Health. We recommend, therefore, that a complete legislative study and survey be encouraged and undertaken in this direction.

(10) It is encouraging to report that the Committee has maintained excellent liaison with the Legislative Interim Committee on Mental Health and has been consulted on matters of importance and areas of common interest.

In conclusion, the Chairman would like to express his warm appreciation to the members of the Committee, Drs. Sullivan G. Bedell, James W. Ettinger, Bernard Goodman and Zack Russ Jr. for their individual and combined efforts in making this a truly active Committee.

ACTION OF COMMITTEE ON MENTAL HEALTH CONCERNING RESOLUTION ON INVOLUNTARY HOSPITALIZATION FOR MENTAL CASES.—The resolution on involuntary hospitalization for mental cases from the Volusia County Medical Society was referred by the 1960 House of Delegates to this Committee for deliberation and reply. The resolution was considered on the dates of October 16 and November 20, 1960, by this Committee.

In Paragraph I of the resolution pertaining to temporary emergency certification and involuntary restraint in hospital for diagnosis and treatment of a mental case by a local physician or physicians pending later form of judicial action in such case, it is the consensus of this Committee that this procedure is provided in the legislative statutes, Chapter 394.21. In Paragraph II of this chapter, which applies to private and county-operated hospitals, any individual may be admitted on appropriate written application and certification by two licensed practicing physicians without awaiting judical proceedings with the head of the hospital having the obligation to report such admission to the County Judge of the county in which such hospital is situated. Paragraph III of this same chapter and subsection allows for emergency hospitalization on medical certification by "at least one licensed physician as in this chapter qualified," whereby it is of the opinion that the individual is mentally ill and, because of this illness, is likely to injure himself or others if not immediately restrained. This paragraph again refers to private and county-operated hospitals. Paragraph IV allows for other than medical authorities, to wit, other law enforcement civil authorities to apply for admission if, in their opinion, the person is mentally ill and, because of illness, likely to injure himself or others if allowed to remain at liberty pending examination and certification by a licensed physician. Paragraph V insures the right to release on application of the involuntary patient so admitted under Paragraphs II, III, and IV, but does make allowance for a delay of release up to five days. It is the consensus of the Committee that in regard to the first paragraph of the resolution, the laws quoted cover the situations outlined.

In regard to the second paragraph of the resolution, suggesting modification of present incompetency laws to permit a separate action of judicial certification, the 1959 legislature enacted or amended Subsection 12 of Section 394.22 to allow for a certification procedure for temporary hospitalization and confinement for a period not to exceed six months if, in the opinion of the Examining Committee, the illness which the patient suffers is of an acute and/or temporary nature and not chronic and/or permanent; this amended subsection also allows for appointment of a temporary guardian, if such be indicated. After the discharge of said person from the hospital, "his civil rights shall be deemed automatically restored."

In regard to the third paragraph of the resolution, it is the opinion of the Committee that the law, as it is now written and since amended, does provide flexibility and does, because of its wording, protect society, the participating physicians, and the patient or the alleged incompetent. Some consideration has been given to the idea of establishing "clear qualifications and perhaps registration of physicians charged for the responsibility and privilege of certification."

Those physicians on the Committee representing the larger counties expressed their own experiences with the use of these new procedures and assured the Committee Chairman that the County Judge in these respected counties does call upon the qualified psychiatrists to serve on the committees, particularly in regard to these certification procedures and has proceeded rapidly in issuing an order for the confinement of those persons alleged to be, or believed to be, dangerous to themselves or to society until such time as appropriate judicial action could be taken. Certain portions of the law are construed by the Committee to indicate that in those counties not having private or county-operated psychiatric facilities, one of these sections could be utilized to effect an immediate admission to State Hospital for the protection of the patient and society.

In conclusion, our Committee wishes to express its appreciation for the interest in this problem as shown by the resolution presented by the Volusia County Medical Society. The Committee will be very happy to furnish copies of the sections of the Florida Statutes referred to if these are not readily available to the interested members of the Volusia County Medical Society.

"The report of the Committee on Public Health is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Public Health

M. EUGENE FLIPSE, *Chairman*

The Committee on Public Health was created as a new committee under the Association's revised By-Laws which became effective in April 1960. Since its activation, the Committee has engaged in considerable thought and discussion relative to its scope and responsibilities.

As of this writing, the Committee has held one official meeting, on March 5, 1961, during which a variety of matters was acted upon. A summary of the Committee's significant activities and actions follows.

(1) A resolution opposing the operation of public blood pressure machines submitted by the Palm Beach County Medical Society was referred to the Committee by the Council on Medical Services. After thorough study and consideration, it was the recommendation of the Committee that the resolution be approved and that the matter be referred to the Committee on State Legislation for implementation at its discretion.

(2) The incidence and status of poliomyelitis in Florida in 1960 was reviewed and evaluated by the Committee. It was pointed out that killed virus vaccine will have to be used during the 1961 polio season because oral live virus vaccine will not be available to any degree for commercial distribution for at least another year. It was suggested that promotional techniques for future immunization programs should be modified and individualized for specific groups in order to achieve greater success among lower socioeconomic groups which contain the greatest proportion of unimmunized persons. The Committee took the following specific actions regarding poliomyelitis.

(a) Endorsed with minor changes the vaccination schedule for formalin-inactivated polio vaccines recommended by the Surgeon General's advisory committee and provided this information to all Florida physicians.

(b) Urged the profession to continue to participate in special surveillance and reporting of all polio-like illness occurring in the state.

(c) Requested physicians and county medical societies to assist in promoting special immunization programs aimed at reaching children under five years of age in lower socioeconomic groups.

(d) Requested physicians and medical societies to assist when indicated in carrying out special immunization, serologic or virologic surveys.

(e) Endorsed the possible use of live poliovirus vaccines for community-wide saturation for control of epidemic poliomyelitis, but specified that the decision for this type of use or in field trials should be made only upon the concurrence of the local health officer, the local medical society and the State Board of Health, with the Committee's advice.

(3) The Committee considered in detail the proposed radiological health program of the State Board of Health and recommended that such a program of surveillance and control of sources of ionizing radiation in Florida be established as a function of the Board of Health and be carried out by regulation under the Board's public health authority rather than by legislation and that because of its importance, the budgetary needs of this program be given a high priority. The Committee also suggested that this method of handling the problem be tried for the next two years and that further studies be continued by the State Board of Health.

(4) An important matter considered by the Committee was the State Welfare Department's rejection of approval for hospital admission under the Public Assistance program for diagnostic services and possible surgery of patients suspected of having early cancer. It was the Committee's consensus that initial early treatment of cancer should be handled on the basis of an acute emergency when indicated and as such be placed in the category of an urgent short term illness requiring operation under this program. In acting upon this matter, the Committee deplored some of the practices of the Welfare Department in its management of policy toward hospitalization of cancer cases and took a position supporting the efforts of all individuals and groups in rectifying this situation.

(5) The Committee was consulted with regard to payment for certain specialized physicians' services to indigent patients. It was the view of the Committee that although the Committee was concerned with the public health aspects of these problems, there were deeper and more basic ramifications outside the scope of this Committee's responsibility. The Committee therefore recommended that these matters be referred to other more appropriate bodies within the Association which already were engaged in studies in this field.

(6) The provision of adequate screening programs for cervical cancer among indigent patients was considered. In regard to this matter, the Committee recommended that Florida physicians and county medical societies assist and support screening programs for cervical cancer in certain county health department clinic indigent patients, subject to the approval of the county medical society involved.

(7) The Committee noted the formation of a joint immunization study committee of the State Board of Health, State Department of Education and Florida Medi-

cal Association which had been recommended by the state School Health Medical Advisory Committee. The Committee pledged all possible assistance to the joint group in carrying out its function of evaluating current laws and regulations affecting immunization and in preparing recommendations for future action.

(8) During the year, the Committee has maintained close liaison with the various bureaus and divisions of the State Board of Health on all matters affecting public health and wishes to express its appreciation for their high degree of cooperation.

"The report of the Committee on Rural Health is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Rural Health

GEORGE W. KARELAS, *Chairman*

Two attempts were made to have a formal Committee meeting but to no avail. The reasons for failing were not only the wide geographic distribution of the several members but also their responsibilities as the only doctors in their respective towns. Nevertheless, there was much accomplished on a state, regional and national level by two members of the Committee.

We participated in the following activities:

1. Attended the American Medical Association's first Regional Rural Health Conference of the Southeastern states in Atlanta.
2. Attended the American Medical Association's third National Study Conference on Rural Health in Chicago.
3. Representing the Association, we attended two meetings of the Florida Committee on Rural Health in Jacksonville and Tallahassee.
4. Representing the Association, we attended two meetings of the Florida Farm Safety Committee in Gainesville.
5. Two major pieces of correspondence requesting information on agricultural migrants in regard to residency laws and Workmen's Compensation policies were handled. The correspondence was between similar rural health committees of the Arizona and Colorado state medical societies.
6. We are honored to have on our Committee Dr. Francis T. Holland of Tallahassee, who was recently appointed Regional member of the Council on Rural Health of the American Medical Association, representing Florida, Alabama, Georgia, Mississippi and Louisiana.

Representation on such committees as the Florida Committee on Rural Health and Florida Farm Safety Committee which have representatives of paramedical and farm groups creates excellent public relations between organized medicine and the rural people of our state. Continued representation on such committees by the Association will not only bring better medical care to the rural areas but create continued good will between the participating groups.

"The committee recommends that resolution 61-1, Indigent Care, by the Escambia County Medical Society, be amended for the last paragraph to read: RESOLVED, That the Florida Medical Association go on record as approving payment to hospitals for all types of correctable illness in the approved medically indigent patients in Florida.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Dr. Holland stated that the way the last paragraph read sounded as though the Florida Medical Association would pay the bills and that this should read: "RESOLVED, that the Florida Medical Association go on record as recommending the approval of payment. . . ."

This amendment was approved.

After discussion by Drs. Hampton, Day, and Williams, the Speaker called for a voice vote on the committee recommendations, as amended, but the vote was inconclusive.

Dr. W. Tracy Haverfield moved, in order to expedite the problem, that the resolution be tabled and referred to the Board of Governors to seek a legal opinion to put this resolution in proper words to carry out the letter of the intent.

The Speaker explained that it was not proper to "table" this motion, if it were to be referred to the Board of Governors; that it should merely be referred.

Motion carried.

Resolution 61-1

Indigent Care
Escambia County Medical Society

WHEREAS the criteria for admission of medically indigent patients to hospitals for diagnosis and treatment is limited to only acute illness or injuries; and

WHEREAS the medical indigent with chronic, correctable, or improvable conditions cannot receive hospital care; be it therefore

RESOLVED, That the Florida Medical Association go on record as approving payment to hospitals for all types of illness in the approved medically indigent patients of Florida.

"On Resolution 61-2, Indigent Care, Migratory Laborers, by the Collier County Medical Society, this resolution is accepted as printed in the Handbook and referred to the Committee on Rural Health for further consideration.

"Mr. Speaker, I move the adoption of this portion of this report."

No discussion; no objections, motion carried.

Resolution 61-2

Indigent Care, Migratory Laborers
Collier County Medical Society

WHEREAS all the physicians and hospitals of South Florida face a difficult financial problem in providing medical care for migrant farm workers; and

WHEREAS Collier County (population 12,000), with 14 practicing physicians and one private 50 bed hospital operated by a nonprofit association, is especially hard hit by an influx of between five and six thousand migrant workers who stay for several months each winter; and

WHEREAS no federal, state, or county funds are available at present to pay hospital and medical costs for these people, the majority of whom have neither insurance nor personal resources to pay for themselves even partially; be it therefore

RESOLVED, That the Collier County Medical Society hereby respectfully request that the House of Delegates of the Florida Medical Association, through an appropriate committee, consider and recommend to the proper authorities the measures it considers most suitable to provide financial assistance for medical and hospital care for migrant agricultural workers.

"Resolution 61-5, Nursing, by the Duval County Medical Society is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-5

Nursing
Duval County Medical Society

WHEREAS efficient, adequate nursing is essential for proper medical care; and

WHEREAS there is now a desperate need for more graduate nurses; and

WHEREAS emphasis in student nursing training has shifted from the bedside to the classroom; and

WHEREAS the cost of administering a school of nursing is becoming prohibitive to most institutions; and

WHEREAS the forty hour maximum prescribed work week is a deterrent to the total use and development of student nurses' capabilities; and

WHEREAS the medical profession is no longer called upon for guidance in matters of nursing policy and education, therefore be it

RESOLVED that facilities to alleviate said nursing shortage be provided by instituting, adding and having schools wherever hospital facilities permit; be it further

RESOLVED that the training be oriented more toward the bedside by allocating more time on the ward and less classroom work; be it further

RESOLVED that nursing education be oriented more toward the economy of hospital administration; be it further

RESOLVED that the forty hour nursing week be liberalized on a voluntary basis and that the student be permitted compensation for time so spent; be it further

RESOLVED that the medical profession participate on a continuing basis in the formation of nursing policy and the administration of nursing schools; be it further

RESOLVED that the Florida Medical Association and the county components exercise a continuing interest in guidance in the field of nursing education in the communities of Florida; be it further

RESOLVED that copies of this resolution be presented to the House of Delegates of the Florida Medical Association for further action at state levels; be it further

RESOLVED that copies of this resolution be presented to the delegates to the American Medical Association for further action at national levels; and be it further

RESOLVED that copies of this resolution be sent to each nursing school in the state, the Florida State Board of Nursing, the American Medical Association, and the National League for Nursing and to each Hospital Administrator.

"Resolution 61-16, Patient Services through Health Departments, is approved in principle. This Committee recommends that this be referred to the Committee on Public Health for study because of the many facets of this particular problem in public health.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-16

Patient Services through Health Departments
Orange County Medical Society

WHEREAS every individual able to pay for his own health care should do so; and

WHEREAS each individual patient receives the best type of care when he has a personal physician supervising his total health needs, therefore be it

RESOLVED that each patient receiving treatment or immunization through the various health departments in the State of Florida, be screened for ability to pay with special attention to borderline cases in long term illnesses such as tuberculosis, mental disease, and cancer; and be it further

RESOLVED that each patient receiving treatment through the various health departments in the State of Florida have his total health care program supervised by a personal physician either in private practice or in a community clinic; and be it further

RESOLVED that this resolution be presented to the House of Delegates of the Florida Medical Association requesting action by the Florida State Board of Health.

"The statement of policy of the American Academy of Orthopedic Surgeons regarding Podiatry in Hospitals is accepted for information only. We recommend that a resolution stating the policy of the Florida Medical Association on this subject be presented by the appropriate groups to the next House of Delegates in collaboration with the interested specialty groups, namely, surgery and orthopedic surgery.

"Mr. Speaker, I move the adoption of this portion of the report."

The speaker asked what Committee this should be referred to. The Chairman was willing to leave this to the discretion of the President.

Motion carried.

A Statement of Policy of the American Academy of Orthopaedic Surgeons on the Practice of Podiatry in Hospitals

1. There is a place for podiatrists in hospitals.

2. The extent of podiatry service should be determined at the local level and vary with the size, type, staff organization of, and service rendered by the hospital.

3. These services should logically be provided in the Out Patient Departments of those hospitals in which podiatrists are permitted to practice and be confined within the scope of the practice of podiatry as authorized by the statutes of the state.

4. The services of podiatrists in hospitals are in the best interest of the public only when rendered under medical supervision and should be confined to the Out Patient Department.

5. The services of podiatrists in hospitals must be rendered under one of the existing Departments or Sections which has been charged with the supervision of podiatry services. Provision of podiatry services in the hospital does not confer on podiatrists the privilege of admitting patients to the hospital.

6. In those hospitals where a podiatrist is permitted to perform surgery as a technician, it is recommended that he be under the direct supervision of a physician. By supervision, it is meant that during the operation, a staff surgeon must be present in the operating room, gowned and scrubbed, as the responsible person.

7. The podiatrists in their relationships with physicians should subscribe to and comply with "Guiding Principles for Relations Between Physicians and Allied Health Professions" as recommended to the A. M. A. by the Committee on Relationships of Medicine with Allied Health Professions and Services, and as adopted by the House of Delegates of the A. M. A., June 16, 1960. (April 15, 1961)

"Mr. Speaker, I move the adoption of this entire report as amended."

No discussion; no objections, motion carried.

REPORT OF REFERENCE COMMITTEE No. III

Finance and Administration

Dr. Miles J. Bielek: "Mr. Speaker, Mr. President and Members of the House of Delegates: Reference Committee No. III on Finance and Administration met with all members present, but with the absence of Dr. Richard F. Sinnott, who passed away shortly before he was to be seated as Chairman of this Committee. The committee missed him, and respectfully requests a moment of silence be observed in his memory."

The House rose for a moment of silence.

"Your Reference Committee gave careful consideration to items referred to it and makes the following report:

"In connection with the report of the Board of Governors the Reference Committee recommended the following changes and addenda:

(1) That paragraph 15 concerning the Committee on Fee Schedules have a sentence added—'There shall be no more than one member from any one specialty group on this Committee.'

Dr Robert E. Zellner and Dr. Wachtel spoke against this amendment.

The amendment proposed by the Reference Committee was defeated by voice vote.

"(2) In Paragraph 3 of Section 3, it is recommended that the words 'whenever necessary' be deleted from the last sentence. It should be required for this Committee to consult with the Council on Specialty Medicine."

No discussion; no objections, motion carried.

"(3) In the section on Annual Meetings it is recommended that a sentence be added as follows: 'It is regrettable that other areas are not functional and serviceable for our group and should other facilities become available, they will be considered.'

"(4) The Committee commends and heartily endorses the selection of Dr. Shaler Richardson as recipient of the Association's Certificate of Merit.

"(5) The Committee commends the Board for the selection of Edward R. Annis, M.D. as recipient of the A. H. Robins Community Service Award. His activity makes him an outstanding example and model that all of our members should emulate.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Report of the Board of Governors

LEO M. WACHTEL, M.D., *Chairman*

During the Association's administrative year and prior to the printing of this report, five meetings of the Board of Governors have been held. They were at Jacksonville on April 11, 1960, Bal Harbour on June 12, 1960, and Jacksonville on September 25, 1960, January 14, 1961, and April 8-9, 1961. Another meeting will be held just prior to the Annual Meeting, and it will be covered in a supplement to this report to be presented to the first meeting of the House of Delegates on May 25, 1961.

I wish to express my deep gratitude to the members of the Board of Governors who have attended meetings at great personal sacrifice of time and have worked diligently at the task of conducting the business of the Association. It has been refreshing to have the opportunity to work this year with such dedicated physicians.

Recommendations

BY-LAWS.—After careful consideration, the Board of Governors recommends to the House of Delegates the following amendments to the current By-Laws of the Florida Medical Association:

CHAPTER IX—COMMITTEES
Section 1. ORGANIZATION

Paragraph 2 shall be amended by changing the title of the Committee on Medical Secretaries and Assistants to: "Committee on Medical Assistants."

Paragraph 7 shall be amended by changing the title of Committee on Maternal Welfare to: "Committee on Maternal Health," and Committee on Conservation of Vision to: "Committee on Vision," and by deleting the Committee on Cancer (abolishment).

Paragraph 10 shall be amended to read:

"The COUNCIL ON SPECIALTY MEDICINE: Committees on Anesthesiology, Dermatology, General Practice, Internal Medicine, Neurosurgery, Obstetrics, and Gynecology, Ophthalmology and Otolaryngology, Orthopedics, Pathology, Pediatrics, Plastic Surgery, Psychiatry, Radiology, Surgery, and Urology.

"Subcommittee on Specialty Groups: Committees on Florida Academy of General Practice; Florida Allergy Society; Florida Society of Anesthesiologists; Florida Chapter, American College of Chest Physicians; Florida Society of Dermatology; Florida Health Officers' Society; Florida Association of Industrial and Railway Surgeons; Florida Society of Internal Medicine; Florida Neurosurgical Society; Florida Obstetric and Gynecologic Society; Florida Society of Ophthalmology and Otolaryngology; Florida Orthopedic Society; Florida Society of Pathologists; Florida Pediatric Society; Florida Society of Plastic and Reconstructive Surgery; Florida Proctologic Society; Florida Psychiatric Society; Florida Radiological Society; Florida Chapter, American College of Surgeons; Florida Association of General Surgeons; Florida State Surgical Division. International College of Surgeons; Florida Urological Society, and any other statewide specialty society recognized by the Association.

Paragraph 11 shall be amended to read:

"THE COUNCIL ON VOLUNTARY HEALTH AGENCIES: Committees on all statewide voluntary

health agencies officially recognized by the Board of Governors."

Section 2. COMPOSITION, SELECTION AND TENURE OF COMMITTEES

Paragraph 10 shall be amended to read:

"10. SPECIALTY MEDICINE COMMITTEES.—Each Committee under the Council on Specialty Medicine shall consist of one member appointed by the President of the Association to represent each medical specialty.

"Subcommittee on Specialty Groups: Shall be composed of one member appointed annually by the President of the Association in consultation with the President of each specialty group officially recognized by the Association."

Add an additional paragraph, 15:

"15. COMMITTEE ON FEE SCHEDULES.—This Committee shall be composed of nine members, two members from each medical district and one from the membership at large; the appointments from the medical districts shall be for a four year term on a staggered basis, and the member at large shall be appointed annually for one year.

Section 3. DUTIES AND FUNCTIONS

Paragraph 3 shall be amended to read:

"3. The COMMITTEE ON FEE SCHEDULES shall be responsible for the study, development, modification, and necessary negotiations of all fee schedules accepted or endorsed by the Association. It shall consult with other appropriate Committees and with the Council on Specialty Medicine."

Add an additional paragraph, 16, to read:

"The COUNCIL ON SPECIALTY MEDICINE shall serve in an advisory capacity to the Committee on Fee Schedules in the development or modification of fee schedules accepted or endorsed by the Association.

"The SUBCOMMITTEE ON SPECIALTY GROUPS shall provide liaison between the specialty organizations and the Association. It shall consult with the Committee on Scientific Work in coordinating meetings held at the time of the Association's Annual Meeting."

ANNUAL MEETINGS.—It is the recommendation of the Board that the following dates and sites be approved for the annual meetings of the Florida Medical Association:

1962	Miami	May 9-13	Americana Hotel
1963	Jacksonville	May 8-12 or 15-19	Robert Meyer Hotel and Civic Auditorium (subject to satisfactory Auditorium rates)
1964	Hollywood	May 6-10 or 13-17	Diplomat Hotel (subject to adequate exhibit facilities)
1965	Miami	April 21-25	Americana Hotel
1966	Miami	May 11-15	Americana Hotel

It is regrettable that other areas are not functional and serviceable for our group and should other facilities become available, they will be considered.

CERTIFICATE OF APPRECIATION.—The Board of Governors recommends the adoption of the following resolution establishing a CERTIFICATE OF APPRECIATION. This resolution is based upon the recommendation of the Orange County Medical Society.

"WHEREAS the vastly extended scope of the activities of the Florida Medical Association makes heavy demands upon the time, talents, and personal sacrifice of the officers and the many faithful members who staff the Councils and Committees and accept special assignments; and

WHEREAS it is fitting that exceptionally meritorious service so rendered in the interest of the Association be appropriately acknowledged; therefore be it

RESOLVED, That the Association establish a Certificate of Appreciation to be presented to members who have performed unusual or outstanding services to the Association, to the medical profession and to the public, as set forth in the Principles of Medical Ethics of the American Medical Association; be is further

RESOLVED, That the certificate constituting the Certificate of Appreciation be granted not oftener than annually by the Board of Governors; and be it further

RESOLVED, That the selection of members to be so honored shall be made by the House of Delegates from nominations made by the Board of Governors. Recommendations may be made by the component county medical societies."

COMPONENT COUNTY MEDICAL SOCIETIES.—Upon the recommendation of the Judicial Council, the Board of Governors changed the members residing in Sumter County from the supervision of the Lake County Medical Society to the Pasco-Hernando-Citrus County Medical Society. Both county medical societies were agreeable to this change. The number of component county medical societies will still remain at 40.

Nominations

BLUE SHIELD BOARD OF DIRECTORS. — The Board of Governors reviewed the nominations for the Blue Shield Board of Directors presented by the Blue Shield Nominating Committee and from the three nominations for each physician directorship the following two were chosen:

Medical District "A"—Three year term	Medical District "B"—Three year term
Luther C. Fisher Jr., M.D.	John S. Stewart, M.D.
George S. Palmer, M.D.	Millard B. White, M.D.

Medical District "D"—Three year term

Ralph W. Jack, M.D.	Donald W. Smith, M.D.

At Large—Three year term

John J. Cheleden, M.D.	James T. Cook Jr., M.D.
John T. Stage, M.D.	Eugene G. Peek Jr., M.D.

The three lay members nominated by the Nominating Committee were approved by the Board as follows:

District "D"—Three year term	At Large—Three year term
	Mr. Arthur Saarinen
Mr. Horace F. Cordes	Mr. Carl G. Rose

COMMITTEE ON MEMBERSHIP AND DISCIPLINE.—As provided for in the By-Laws, the Board nominates for re-election the four physicians whose terms expire on the Committee on Membership and Discipline in 1961. They are:

District 1 C. Frank Chunn, M.D., Tampa
District 4 Frazier J. Payton, M.D., Miami
District 5 Duncan T. McEwan, M.D., Orlando
District 8 William C. Thomas Sr., M.D., Gainesville

(Additional nominations may be made from the floor of the House of Delegates.)

CERTIFICATE OF MERIT. — Your Board recommends that Shaler Richardson, M.D., be awarded the Association's Certificate of Merit (complete nomination will be included in the delegates' packets).

Major Activities

ANNUAL MEETING. — The Board approved the schedule and program of the meeting submitted by Thad Moseley, M.D., Chairman of the Committee on Scientific Work. The format differs from that in previous years in that the meeting will begin on Thursday, May 25, and end on Sunday, May 28, providing more utilization of the weekend. The Board, upon approval of the majority of the 21 specialty groups, moved their meetings from Sunday to Saturday afternoon and Sunday morning. The scientific program again this year is being presented in cooperation with a number of the special interest groups.

BUDGET.—The Board carefully reviewed a financial statement and an audited statement presented by Samuel M. Day, M.D., Secretary-Treasurer, which will appear in the annual report of the Secretary-Treasurer and the Executive Director. In 1960, the Association had an income

from all sources of $250,067.85. Total expenses incurred were $235,423.41 for a net excess of income over expense of $14,644.44. Your Board approved an annual operating budget for the calendar year 1961 in the amount of $217,291.00 plus a 5 per cent for reserve in the amount of $11,000, for a total of $228,291.00. This budget was presented by the Executive Director in consultation with the Secretary-Treasurer, and is based upon an anticipated income of $232,000.00.

GENERAL PRACTITIONER OF THE YEAR.—The Board of Governors carefully reviewed the nominations for the General Practitioner of the Year award and nominated James T. Cook Jr., M.D. of Marianna to the American Medical Association for its consideration. We are pleased to advise that Dr. Cook was selected by the American Medical Association for this honor at its meeting in December 1960.

COMMUNITY SERVICE AWARD.—The Board reviewed the nominations received for the A. H. Robins Award for "Outstanding Community Service by a Physician" and selected Edward R. Annis, M.D., of Miami for the Award.

RADIOLOGY.—The Board received the report of the Association's representatives on the Joint Committee on Radiology composed of representatives of the Florida Medical Association, Florida Radiological Society, Blue Cross and Blue Shield of Florida, and Florida Hospital Association. This Committee was established to consider a request from the Florida Radiological Society for the active support of the Association in preventing further violation of the Laws of Florida and policies of the Association by Blue Cross of Florida in providing x-ray diagnostic benefits. The Blue Cross of Florida and the Florida Hospital Association representatives would not agree to the position taken by the representatives of the Florida Medical Association, Blue Shield of Florida, and the Florida Radiological Society. The Board referred the matter to the Association's Judicial Council for consideration and further action.

MEDICARE.—The Board approved the recommendation of the Medicare Mediation Committee to extend the Association's contract for another year (May 1, 1961 to April 30, 1962).

AMERICAN MEDICAL ASSOCIATION ANNUAL MEETINGS.—The Association served as host to the American Medical Association for its annual meeting in June 1960 in Miami Beach. Six other southeastern state medical associations assisted our Association in serving as host and the financial obligations of the Association were kept at a minimum. Your Board has extended an invitation to the American Medical Association through its Board of Trustees to hold either its annual meeting or clinical session in Florida at any time in the future the Board of Trustees deems it advisable.

FLORIDA MEDICAL ASSOCIATION PROPERTY.—The Board purchased the property located at 731 Standish Place. This property is 50 feet by 220 feet deep, immediately to the rear of the Association's building, and extends to the St. Johns River. The building on it has been demolished and the space used for parking at the present time and held for future expansion of the Association.

VOLUNTARY HEALTH AGENCIES.—In compliance with the By-Laws and Rules adopted by the Board, the following voluntary health agencies applied for recognition and were approved by the Board: Florida Division, American Cancer Society, Florida Heart Association, Florida Chapter, Arthritis and Rheumatism Foundation, Florida Association for Mental Health, Florida Society for Crippled Children and Adults, and Florida Tuberculosis and Health Association.

RESEARCH.—The Board approved the following definition of research as recommended by the Judicial Council: "Medical research is a plan for deliberate approach to scientific health problems where more knowledge is required and from which study there is expected to result a greater understanding of disease processes which will result in improvement of the diagnosis, treatment, and prevention of human suffering."

FLORIDA MEDICAL ASSOCIATION INVESTMENT TRUST.—Upon the recommendation of the Florida Medical Association Investment Trust Committee, the Board expanded the Committee from six to 10 members. Seventy-five members of the Association are now actively participating in this Restricted Retirement Program.

GOVERNOR'S CITIZENS ADVISORY COMMITTEE ON AGED.—The Board carefully reviewed the report of the Governor's Citizens Advisory Committee on the Aged, went on record as objecting to those provisions of the majority report that recommended the financing of medical services through the Social Security Program, and endorsed certain specific recommendations contained in the minority report.

NATIONAL CONVENTIONS.—The Board sponsored Ralph W. Jack, M.D., of Miami, to attend the Republican National Convention as a delegate, and Edward R. Annis, M.D., of Miami, as alternate delegate to the Democratic National Convention.

TELEVISION PRODUCTION.—The Board authorized the co-sponsorship of the Association with Sen. George A Smathers for the production of a television film telling the story of Florida's program for indigent hospitalization. This film was broadcast by a large number of television stations in Florida.

JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION.—The Board expressed its appreciation to Shaler Richardson, M.D., Editor, for his many years of outstanding service to the Association and appointed him Editor Emeritus of The Journal, effective May 28, 1961. The Board also appointed the Chairman of the Scientific Council (Thad Moseley, M.D.) as Editor pro tem of The Journal, effective May 28, 1961.

REFUGEE CUBAN PHYSICIANS.—The Board established a committee for the placement of refugee Cuban physicians composed of representatives of the Florida Medical Association, State Board of Health, State Board of Medical Examiners, Florida Hospital Association, and the Governor's Office. The report of the Committee Chairman, Franklin J. Evans, M.D., of Coral Gables, will be contained in the supplementary report of the Board to the House of Delegates.

CHILD IMMUNIZATION STUDY.—The Board authorized the establishment of a joint study committee to evaluate state laws and formulate necessary recommendations for new legislation and regulations regarding immunization of school children. This committee has representatives from the Association, State Board of Health, and State Department of Education.

AMERICAN MEDICAL ASSOCIATION TRUSTEES.—The Board authorized the nomination of Homer L. Pearson Jr., M.D., for election to the Board of Trustees of the American Medical Association at its annual meeting in June 1961.

AUTO CRASH INJURY RESEARCH.—The Board approved in principle participation in a program of auto crash injury research in Florida in cooperation with Cornell University, the Florida Department of Public Safety, and the State Board of Health.

INDIGENT MEDICAL CARE.—The Board approved a program of medical care of the needy sick in Florida which recommended that the intrastate cost of a comprehensive medical care program for the care of all needy sick in Florida be shared by the state and counties so that the state would not be required to increase greatly its present expenditures for this service and the counties would gain tax relief afforded by federal reimbursement.

ADOPTIONS.—The Board recommended that the Department of Public Welfare make preplacement investigation in adoptions.

SUBCOMMITTEE ON PREGNANCY WASTAGE AND PERINATAL MORTALITY.—The Board established a Committee on Pregnancy Wastage and Perinatal Mortality composed of representatives of the Florida Medical Association's Committees on Maternal Health and Child Health, the Bureau of Maternal and Child Health of the State Board of Health, and the Florida Pediatric Society.

ASSISTANCE TO COUNCILS AND COMMITTEES.—During the past year a great deal of time and effort

was put forth to implement the provisions of the Charter and By-Laws which grouped the numerous Committees of the Association under the 10 Councils. The Board had the opportunity and privilege to work closely with these Councils. At the meeting of the Board on April 8-9, 1961, all council reports were carefully reviewed and are transmitted to the House of Delegates in the Delegates' Handbook. Specific recommendations of the Board regarding these reports will be presented to the Reference Committees.

"In reviewing the annual report of the Secretary-Treasurer-Executive Director, it is noted that the income from technical exhibits and advertising has decreased, and noted that this is a trend throughout the country. Our recommendation concerning this decrease in revenue is that some means be explored to stimulate increased income from technical exhibitors and advertising. The Committee feels that members of the Association should make every effort to attend the technical exhibits and thus stimulate interest on the part of the exhibitors. The Committee recommends to the Board of Governors that they furnish the House of Delegates with a more detailed yearly financial statement in the future.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Annual Report

Secretary-Treasurer, Samuel M. Day, M.D.
Executive Director, W. Harold Parham

This report covers the administrative year 1960-1961 and is submitted as a brief summarization of the many and varied activities of the Secretary-Treasurer, the Executive Director and the Executive Office during this period. The Association's over-all activities have been covered in the Board of Governors, Council and Committee Reports presented to the House of Delegates.

SECRETARY-TREASURER

The constitutional Secretary has carried out the various duties required by the By-Laws of the Association and the functions requested by the Board of Governors. The Secretary has also attended as many national, regional, state and Association Council and Committee meetings as possible during the year.

Membership of the Association has exceeded all previous records with a total of over 4,150 members. Less than 105 of this number are retired, and an additional 541 physicians were licensed in Florida this year. There are approximately 5,400 licensed Florida physicians who reside in the state.

The report of the Treasurer, including the financial statements, covers the period January 1 through December 31, 1960. The books have been audited by Lucas, Catherwood and Associates, Certified Public Accountants, and their Certificate of Audit is incorporated in the statements which appear at the end of this report. In summary, the income, expenditures, and gross gain are as follows:

INCOME	
Dues and Fees	$ 153,740.00
Journal	57,369.64
Directory	2,289.00
Technical Exhibits	14,740.00
Interest	2,717.35
Special Service	12,014.25
Increment in Value—Pension Trust	7,197.61
	$ 250,067.85
EXPENDITURES	
General	$ 93,069.43
Executive Director's Dept.	18,583.85
Administrative Department	33,477.62
Public Relations Department	14,970.47
Publications Department	21,708.60
Legislative Department	16,164.38
Building and Grounds	13,446.06
Depreciation and Inventory Adjustment	11,332.40
Special Services	12,070.60
Miscellaneous	600.00
	$ 235,423.41
Net Excess of Income over Expenditures	$14,644.44

The Board of Governors approved the proposed budget as prepared by the Executive Director in consultation with the Secretary-Treasurer for the 1961 calendar year as follows:

General	$ 94,650.00
Executive Director's Department	19,635.00
Administrative Department	34,518.00
Public Relations Department	16,965.00
Publications Department	21,385.00
Legislative Department	17,623.00
Building and Grounds	12,515.00
Reserve	11,000.00
	$228,291.00

This budget was based upon an anticipated income for the 1961 calendar year as follows:

Dues and Entrance Fees	$157,000.00
Advertising, Journal and Directory Sales	52,000.00
Technical Exhibit Space	20,000.00
Interest and Miscellaneous Income	3,000.00
	$232,000.00

The anticipated income is less than projected during the two previous years because of a marked decrease in advertising in The Journal. There has been a cutback by pharmaceutical companies in promotional advertising nationwide.

EXECUTIVE DIRECTOR

The Executive Director has carried out the duties and responsibilities as directed by the Board of Governors, which include the general responsibility to carry out the directives of and service to the House of Delegates, Board of Governors, Executive Committee, Officers, and American Medical Association Delegates, and the development, organization, coordination and implementation of the over-all activities of the Association, management of finances, executive office, personnel and headquarters building, supervision of the annual convention, administrative liaison with the American Medical Association and county medical societies, and the rendering of administrative services to certain Councils and Committees of the Association.

EXECUTIVE OFFICE

The administrative structure of the Executive Office was continued as during the previous year and was divided into the Administrative Department, Mrs. Zoe Pack, Director; Public Relations Department, Mr. Eugene L. Nixon, Director; Legislative Department, Mr. Alvin D. James, Director; Publications Department, Mr. Thomas R. Jarvis, Director; and Special Services, Mrs. Mae Mason. The various duties, activities, and Council and

Committee assignments were allocated to these departments. Additional personnel of the Executive Office are Mrs. Wanda Bain, Miss Margaret Brown, Mrs. Rita Fitzgerald, Miss Frances Pesce, Mrs. Louise Rader, Mrs. Ann Seales, Mrs. Helen Walker, Miss Lois Young, and Mr. Henry L. Maree.

CONSULTANTS

Mr. Harry T. Gray of the firm of Marks, Gray, Yates, Conroy & Gibbs continued to serve as legal counsel for the Association, and Mrs. Edith B. Hill as Editorial Consultant. Lucas, Catherwood and Associates are the Association's Certified Public Accountants.

ACTIVITIES

ADMINISTRATIVE ASSISTANCE for the Officers, Board of Governors, standing Councils and special Committees of the Association, maintenance of proper records and files, assistance to county medical societies in planning and implementing programs, and liaison with other national and state medical and lay organizations composed a major portion of the activities of this past year as in previous years. Administrative assistance has also been provided to special groups such as the Committee on Medicine and Hospitals, Florida Joint Council to Improve the Health Care of the Aging, Florida Committee on Rural Health and Florida Joint Committee for the Improvement of Patient Care.

FIELD SERVICES comprised one of the major activities of the Executive Director, Public Relations Director and Legislative Director during the year. Contacts were made with component county medical societies, legislators, news media and other organizations in the interest of liaison and carrying out the programs of the Association.

THE JOURNAL of the Florida Medical Association report covers the 12 issues ending with December 1960. There were 51,600 copies printed, which is an increase of 4,000 over the previous year. Income from advertising for the third consecutive year has been adequate to cover the cost of printing, engraving, paper and drayage incurred in publishing The Journal.

THE FLORIDA MEDICAL DIRECTORY was compiled and 5,800 copies were printed. Each active member of the Association was furnished a complimentary copy. Roster number three of licensed nonresident physicians was eliminated in the 1961 Directory and in its place the Charter and By-Laws of the Association were published.

BRIEFS were prepared and sent to all members of the Association whenever the need for dissemination of information to the entire membership warranted. Seven issues of Briefs were published during the year.

ANNUAL MEETING required, as in the past, continued attention to the details, records and correspondence in connection with the selection of the scientific program, speakers, technical and scientific exhibitors and other details.

ACCOUNTING AND PURCHASING procedures for the entire organization are maintained on a monthly as well as an annual basis. The posting and crediting of all dues, and acknowledgments to members, the American Medical Association and the county societies as well as the banking are handled in an efficient manner. Daily balances are also maintained and statistical data are readily available.

SPECIAL PROJECTS carried out during the year consisted primarily of fair exhibits, science fairs, rural health, and promotion of the Florida Medical Foundation. The fifth annual Association awards for medical aptitude at the Florida State Science Fair were presented in 1961.

PHYSICIAN PLACEMENT service involved personal interviews, a large volume of correspondence with physicians seeking locations, field contacts and an increased correspondence with communities seeking medical care. Physician placement service during the past year provided assistance to physicians inside and outside the state seeking Florida locations, to Florida physicians seeking associates and to communities in need of additional medical coverage. During the year an average at all times of approximately 100 locations and more than 300 physicians necessitated a heavy volume of correspondence, personal interviews and field visits.

LEGISLATION received special emphasis again this year through assisting the Council on Legislation and Public Agencies in carrying out the Association's program regarding national and state legislation and liaison with governmental agencies regarding health services. The Association maintained an office in Tallahassee during the entire 1961 session of the Florida Legislature to coordinate the Association's legislative activities and serve as a clearing house for legislators and members of the Association.

PRESS RELEASES on various phases of the 1960 annual meeting furnished to the state's newspapers and complete press facilities maintained during the meeting resulted in excellent state coverage. Special press releases regarding the Association's activities or actions were prepared and distributed during the year as warranted. It is gratifying to note that high percentage of Association releases was published with little or no alternation by the press. The Association's weekly health column service, "Health Topics," now enters its twelfth year and still maintains high popularity among the weekly newspapers publishing it regularly.

RADIO AND TELEVISION stations were provided with transcribed programs and films obtained largely from the American Medical Association. Assistance was also furnished to county medical societies in producing local programs. A special television production was prepared in cooperation with Sen. George A. Smathers, telling the story of Florida's program for indigent hospitalization. This production was broadcast by the major television stations in Florida.

MOTION PICTURES provided by the American Medical Association were scheduled and obtained for showing to medical and nonmedical groups.

LITERATURE published by the Association and the America Medical Association, such as pamphlets, booklets, and brochures, was distributed in large quantities to medical societies and other groups, individual physicians and the public at large through waiting rooms, fair exhibits and other activities. Special emphasis has been placed upon distribution and utilization of literature outlining the positive program of American medicine on medical service for the aged and arguments against tying medical care for the aged in with the Social Security system.

MEDICARE required a great deal of administrative assistance again this year in processing the correspondence and reports on claims, together with processing of committee minutes and directives.

FLORIDA MEDICAL FOUNDATION received its entire administrative service needed to function from the staff of the Association. The Executive Director of the Association also serves as Executive Secretary of the Foundation.

SPECIALTY GROUPS approved by the Association have been eligible to receive administrative assistance from the Executive Office since January 1, 1960. Six specialty groups currently are utilizing this service.

SPECIAL PROGRAMS OF THE ASSOCIATION requiring attention during the year were inauguration of the Florida Medical Association Investment Trust and continued servicing of the Association's insurance programs.

INDIVIDUAL ASSISTANCE was provided to each member of the Association requesting it whenever possible.

January 10, 1961

Board of Governors
Florida Medical Association, Inc.
Jacksonville, Florida
Gentlemen:

We have made an examination of the books and records of

FLORIDA MEDICAL ASSOCIATION, INC.—JACKSONVILLE, FLORIDA
as of and for the year ending December 31, 1960, and submit herewith the report thereon, consisting of the three exhibits and two schedules listed in the foregoing Index.

This report was prepared on a cash receipts and disbursement basis, modified by depreciation and inventory adjustments, in a manner similar to that of prior years. Also, this report reflects the Association's present interest in certain assets of the Florida Medical Association Pension Trust For Employees, as of December 31, 1960. The values of the assets of the Trust shown herein, as well as the changes therein during the year under review, are those furnished by Title & Trust Company of Florida, Jacksonville, Florida, Trustee, without independent audit thereof by the undersigned.

The examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as were deemed necessary under the circumstances.

In our opinion the accompanying Statement of Financial Condition and related Statements of Net Worth and Operations presents fairly the financial position of Florida Medical Association, Inc. at December 31, 1960 and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,
Lucas, Herndon & Catherwood

STATEMENT OF FINANCIAL CONDITION
December 31, 1960
FLORIDA MEDICAL ASSOCIATION, INC. — JACKSONVILLE, FLORIDA
ASSETS

CURRENT ASSETS				
Cash On Deposit In:				
Checking Accounts:				
Atlantic National Bank	$ 11,162.28			
Florida National Bank	408.21	$ 11,570.49		
Savings Accounts:				
American National Bank	11,478.83			
Atlantic National Bank	7,045.05			
Barnett National Bank	25,808.91			
Central National Bank	2,862.74			
Florida National Bank	7,069.47			
First Federal Savings and Loan Association	10,888.50	65,153.50		
Petty Cash Fund		105.54		
Total Cash			$ 76,829.53	
Deposit—Universal Travel Plan			425.00	
Inventory—Stationary, Postage and Supplies			2,567.39	
TOTAL CURRENT ASSETS				$ 79,821.92
INVESTMENTS				
U. S. Treasury Bonds—2 ½% Interest:				
Due 1962-67 (Face Value $1,000.00) —				
At Cost		978.44		
Due 1967-72 (Face Value $15,000.00) —				
At Cost		15,176.93	16,155.37	
Association's Interest In Employees Pension Trust:				
Cash Surrender Values—Life Insurance Policies		11,131.41		
Advance Premiums Paid		21,635.08		
Cash Funds In Trust Account		1,185.42	33,951.91	
TOTAL INVESTMENTS				50,107.28

FIXED ASSETS				
Description	Cost	Accumulated Depreciation	Book Value	
Land	$ 73,347.95	-0-	$ 73,347.95	
Building	122,708.52	$ 15,952.12	106,756.40	
Furniture and Equipment	46,800.54	24,958.13	21,842.41	
Totals	$242,857.01	$ 40,910.25	$201,946.76	
FIXED ASSETS—NET				201,946.76
TOTAL ASSETS				$331,875.96

LIABILITIES AND NET WORTH

NET WORTH		
Net Worth—Exhibit "B"	$331,875.96	
Total Net Worth		331,875.96
Total Liabilities and Net Worth		$331,875.96

EXHIBIT "A"

STATEMENT OF NET WORTH
Year Ended December 31, 1960
FLORIDA MEDICAL ASSOCIATION, INC. — JACKSONVILLE, FLORIDA

BALANCE—JANUARY 1, 1960	$317,231.52
ADDITIONS—CURRENT YEAR	
Net Excess of Income Over Expenses—	
Exhibit "C"	14,644.44
BALANCE—DECEMBER 31, 1960—To Exhibit "A"	$331,875.96

Exhibit "B"

STATEMENT OF OPERATIONS
Year Ended December 31, 1960
FLORIDA MEDICAL ASSOCIATION, INC. — JACKSONVILLE, FLORIDA

INCOME			
1960 Dues:			
Active Members Dues	$134,660.00		
Associate Member Dues	5,460.00		
Total 1960 Dues—Schedule C-2	140,120.00		
1960 Entrance Fees—Schedule C-2	4,970.00	$145,090.00	
1961 Dues and Entrances Fees—Schedule C-2		8,530.00	
1959 Dues—Accepted in 1960 By Board Action		120.00	
Advertising Income:			
Journal	56,696.59		
Directory	615.00	57,311.59	
Technical Exhibit Income		14,740.00	
Directory Sales		1,674.00	
Contributions—1960 A.M.A. Convention (Southeastern States)		7,000.00	
Medicare Program-Reimbursements		2,497.38	
Special Services-Reimbursements		2,516.87	
Interest Income		2,717.35	
Journal Subscriptions and Sales		673.05	
Net Increment In Values of Employee Pension Trust Assets:			
Cash Surrender Value—Life Insurance Policies	4,518.40		
Advance Premiums Paid	4,287.36		
Cash Funds In Trust Account	(1,608.15)	7,197.61	
TOTAL INCOME			$250,067.85
EXPENSES—Schedule C-1			
General		108,048.90	
Executive Director		18,583.85	
Administrative		38,819.89	
Public Relations		14,970.47	
Publications		21,708.60	
Legislative		16,164.38	
Building		17,127.32	
TOTAL EXPENSES			235,423.41
NET EXCESS OF INCOME OVER EXPENSES—To Exhibit "A"			$ 14,644.44

EXHIBIT "C"

In the report of the Subcommittee on Medical Hypnosis, the Committee recommends that the last sentence in paragraph No. 1, page 56 in the Handbook be deleted; it recommends that paragraphs 2, 3, 4 and 6 be deleted; it recommends the deletion of the first sentence of paragraph 8 and the addition of a phrase to the third sentence " . . . and with the patient's consent," so that sentence reads: "Anyone practicing hypnotism for medical purposes who is not a licensed physician or dentist should do so under the direct supervision and responsibility of a legally licensed physician or dentist, and with the patient's consent." It is further recommended that special emphasis be placed on paragraph 5; recommended that paragraph 10 be deleted and a paragraph be added to read: "We recommend that the above be the policy of the Florida Medical Association and that the practice of hypnotism in Florida be under the control of the Medical Practice Act."

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Subcommittee on Medical Hypnosis

WILLIAM C. ROBERTS, *Chairman*

The Subcommittee on Medical Hypnosis appointed by Dr. Ralph W. Jack begs to make the following report:

The Subcommittee was unable to meet personally in a body to consider this problem. Considerable correspondence was received from the members expressing their opinions. Other sources, such as publications of

other doctors with reference to this subject, plus a personal interview by the Chairman of this Subcommittee with the chairman of the committee on hypnosis of the American Medical Association, have made this report possible with some degree of intelligence and reasoning and expression.

As Chairman of this Subcommittee I will attempt to give my interpretation of the problem as gleaned from these sources of information plus my own opinion.

1. Hypnosis seems to be a growing problem to the medical profession.
2. Anyone who practices hypnotism should be well trained before attempting to apply it to others. He should be well versed in its dangers as well as its virtues, and in a knowledge of how to cope with both. Well trained, however, has yet to be defined, scaled, or specified.
3. While we as physicians cannot control the stage hypnotist or anyone who uses hypnotism for entertainment purposes, yet we do not condone this practice. As is now being done in medical literature, but not enough it seems, the laymen as well as the profession should be cautioned of its dangers and limitations.
4. Anyone practicing hypnotism for medical purposes should be a legally licensed physician. Anyone practicing it for medical purposes who is not a licensed physician or dentist should do so under the direct supervision and responsibility of a legally licensed physician or dentist, and with the patient's consent. This category is not recommended but is perhaps permissible.
5. Anyone who practices hypnotism, whether for entertainment or medical purposes, should have to prove by proper examination that he is well versed in psychiatry, psychology, physiology and neurology.
6. We recommend that the above be the policy of the Florida Medical Association and that the practice of hypnotism in Florida be under the control of the Medical Practice Act.

"On the report of the Judicial Council, the Committee approved the section regarding Rules and Procedures. The Committee did not approve 60-1, the opinion rendered on the naming of office buildings, which is printed on page 58 of the Handbook. This opinion was not approved because further hearings revealed that the last paragraph is in error insofar as the custom of the local community for naming buildings is concerned. The naming of buildings so designated under specialty group headings has not been condoned and is considered unethical by the Broward County Medical Association. We, therefore, disapprove this portion of the report.

"The supplemental report of the Judicial Council concerning the meeting of the Lake County Medical Society is approved. We recommend that the supplemental report of the Judicial Council concerning Osteopathy have all portions deleted with the exception of the first two paragraphs and the last paragraph. The Committee further recommends that the Florida Medical Association fully support any county association, society or group of doctors who are members of the Florida Medical Association and who may experience difficulty with incompetent physicians or cultists attempting to gain admission to the staff of a hospital. This would include financial support if necessary.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Judicial Council

HOMER L. PEARSON JR., *Chairman*

The first function of the Judicial Council this year was to draft Rules and Procedures for the Council to implement and augment the provisions of the Association's By-Laws. The Rules and Procedures were approved by the Board of Governors on June 12, 1960, and read as follows:

RULES AND PROCEDURES

1. The Judicial Council shall have original jurisdiction, both as to fact and procedure, in all questions and controversies which pertain to interpretation of the Charter and By-Laws, medical ethics, dissension and disputes among members, grievances, membership and discipline. Opinions of the Judicial Council shall be final.
   In any investigation regarding a member of the Association by the Judicial Council or any of its Committees, the physician or physicians being investigated shall have the opportunity to appear before the Council or Committee and present statements of fact in their own behalf.
2. Requests for interpretation of the Charter and By-Laws shall be referred to the Judicial Council for an opinion. Requests shall be in writing. The Judicial Council on its own motion may render an opinion concerning the interpretation or application of the Charter and By-Laws.
3. Grievances from the public (patients) shall be referred to the component county medical society by the Chairman of the Grievance Committee for investigation and an opinion. If the component county medical society does not act within sixty (60) days, the Grievance Committee shall assume original jurisdiction, investigate and make recommendations to the Judicial Council.
4. Dissension and disputes among members of the Association, questions regarding membership, disciplining of members, factualness of medical testimony, medical ethics, professional competency, complaints from other Councils of the Association, other organizations or agencies, shall be investigated by the Committee on Membership and Discipline, and its recommendations reviewed by the Judicial Council.
5. Complete findings and recommendations as to disciplinary action shall be made through the Board of Governors and if the disciplinary action recommended by the Judicial Council involves: (a) medical ethics, the Board shall recommend appropriate action by the component county medical society; (b) matters of law, whether civil or criminal, they shall be referred to the Committee on Medical Licensure for reporting to the State Board of Medical Examiners.
6. The obtaining of biographical data on members of the Association and the obtaining and preparation of obituaries on deceased members of the Association shall be accomplished by the Committee on Archives.

Supplemental Report of Judicial Council

HOMER L. PEARSON JR., *Chairman*

The Judicial Council had a recent meeting with the Lake County Medical Society. This was a dinner meeting and a majority of the members of the society were present. Many of them entered into the discussion of the various problems within the organization.

The meeting was pleasantly and amicably conducted and was adjourned upon a note of good cheer and fellowship.

Supplemental Report of The Judicial Council

HOMER L. PEARSON JR., *Chairman*

An oral request from the Florida Osteopathic Association to the Executive Committee of the Board of Governors of the Florida Medical Association for representatives of the Florida Medical Association to meet with representatives of the Florida Osteopathic Association to discuss staff privileges for Doctors of Osteopathy was made January 13, 1961.

This request has been referred to the Judicial Council of the Florida Medical Association for further consideration and recommendation.

We, therefore, favor the request for a liaison committee to be appointed immediately and to act immediately to study and confer with each other on all matters of interest and concern to both groups.

"The report of the Committee on Grievance is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Grievance

FRANCIS H. LANGLEY, *Chairman*

The Committee on Grievance has received about the usual number of complaints from the public regarding members of the Association. They have been referred to the respective component county medical societies and have been adjudicated in a satisfactory manner.

"The report of the Committee on Medical Licensure is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Medical Licensure

HOMER L. PEARSON JR., *Chairman*

The Committee on Medical Licensure has been involved primarily with the revision of the Medical Practice Act. The provisions of the revision were approved by the House of Delegates in 1960 and will be submitted to the 1961 session of the Florida legislature by the Association's Committee on State Legislation.

"The report of the Committee on Membership and Discipline is approved.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Membership and Discipline

WILLIAM C. THOMAS SR., *Chairman*

The Committee on Membership and Discipline considered three appeals of members from the action taken against them by their county medical societies. The Committee, after conducting a hearing, denied the appeals of the decision of the county medical societies.

A complaint of unethical conduct filed by physicians against a member of another county medical society practicing in their community has been referred to the individual physician's county medical society for consideration.

A multiphased complaint by individual members of a county medical society has been referred to the Judicial Council to investigate and adjudicate.

"The report of the Committee on Archives is approved as printed in the Handbook, and the supplemental reports are also approved.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Archives

CLIFFORD C. SNYDER, *Chairman*

The Committee on Archives has continued its effort to complete the Archives Data on a group of approximately 550 members of the Association. It is the hope of the Committee to continue this program, eventually covering the entire Association membership. From the material obtained thus far, your Committee has prepared an exhibit for the Annual Meeting in May.

Since the 1960 report of this Committee was prepared, there have been 44 deaths involving members of the Florida Medical Association. These have been acted upon, and the names, dates and county society membership follow:

March 1960		
	Miles A. Collier	DeSoto-Hardee-Glades
	Leonard N. Moe	Duval
April 1960		
	Stephen A. Dawson	Pinellas
	Jerome M. Greenhouse	Broward
	Stephen P. Gyland Sr.	Hillsborough
	H. Bernard McEuen	Duval
May 1960		
	Edward F. Aarons Jr. (Col.)	Escambia
	Lester I. Berk	Dade
	Guy S. Selman	Seminole
	Thomas C. Stansbury Jr.	Sarasota
June 1960		
	George P. Beach	Volusia
	George S. Berg	Dade
	Sanford C. Colley	Lake
	Royal H. Mayhew	Broward
July 1960		
	W. McL. Shaw	Duval
	Benjamin L. Whitten	Dade
August 1960		
	Silas M. Copeland	Duval
	Ralph J. Greene	Taylor
	Louie Limbaugh	Duval
	Wm. S. Manning	Duval
September 1960		
	Godfrey L. Beaumont	Highlands
	Kenneth E. Montgomery	Palm Beach
	A. F. Thomas	Brevard
October 1960		
	Chadbourne A. Andrews	Hillsborough
	Randolph Shevach	Dade
November 1960		
	Robert R. Harriss	Broward
	Porter J. Hudson	Pasco-Hernando-Citrus

William E. Kendall	Pinellas
Laurent L. LaRoche	Brevard
Henry L. Tippins	Dade
December 1960	
Elmer B. Campbell Sr.	Pinellas
Elizabeth M. Knott	Pasco-Hernando-Citrus
Dodge D. Mentzer	Polk
Thomas W. Roche	Duval
Maurice J. Rose	Dade
January 1961	
Arthur L. Walters	Dade
February 1961	
Laurin L. Andrews	Dade
Grady H. Brantley	Palm Beach
Francis W. Glenn	Dade
Joseph L. Kinzie	Polk
March 1961	
George W. Croft	Duval
George A. Mitchell	Dade

Supplemental Report of Committee on Archives

CLIFFORD C. SNYDER, *Chairman*

In addition to those reported in the Handbook, the Association has also lost the following members through death:

April 1960	
Frank S. Whitman	Palm Beach
November 1960	
Porter J. Hudson	Pasco-Hernando-Citrus
March 1961	
LeRoy A. Wylie	Pinellas
William H. Grace	Lee-Hendry
April 1961	
Edwin H. Brown	Clay
May 1961	
Philip B. Paty	Pinellas
Harry F. Watt	Marion
Richard F. Sinnott	St. Lucie
Louis M. Orr	Orange
Burton F. Barney	Palm Beach

Your Committee on Archives has concentrated attention this past term on completing a file on our members who are 60+ years of age. This year we will devote our time to those men of 50+ years. We appeal to all members receiving applications to fill them in completely and send any photos or interesting data. We do not wish to delete any member from this distinguished roster; so inform us of such if this may happen. Visit our first exhibit "History of Medicine."

The Speaker recognized Dr. Walter W. Sackett Jr. of Dade.

Dr. Sackett read a resolution in memory of Dr. Richard F. Sinnott.

WHEREAS, the Florida Medical Association moved into its Eighty-Seventh Annual Convention with a selection of superior presiding officers, and

WHEREAS, among these persons was the delegate from Fort Pierce who was to chair the Reference Committee on Finance and Administration and preside over our Third Scientific Assembly, and

WHEREAS, the same person was active in participation and leadership in the Florida Medical Association and the Florida Academy of General Practice, and

WHEREAS, we were deprived of his presence and services by his shocking and untimely death, now, therefore, be it

RESOLVED, that this august body in meeting assembled go on record as deploring this occasion of sorrow precipitated by the unexpected death of Richard F. Sinnott and that a moment of silent contemplation be ordered and, furthermore be it

RESOLVED, that a copy of this resolution be spread on the minutes of this meeting of the Florida Medical Association and that a copy of this resolution, with a personal expression of sympathy, be forworded to his wife, and now widow, Beth, and to his children.

Motion carried.

Dr. Bielek: "The remarks of the Speaker are approved as read at the first meeting of the House.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"The report of the Florida State Board of Medical Examiners is approved as presented.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Medical Licensure

HOMER L. PEARSON JR., *Chairman*

During 1960 The Florida State Board of Medical Examiners examined for licensure 664 applicants; 541 received licenses, approximately 18 per cent failed.

We held eleven hearings on narcotic violations which resulted in three licenses being revoked, two licenses suspended with the suspension not enforced and the physicians placed on probation with no narcotic privileges and one of the physicians required to appear before the Board at each regularly scheduled meeting; five physicians were reprimanded, four of these with the recommendation that they not be permitted to register for a narcotic tax stamp. One hearing on the charge of unprofessional conduct was continued. One license was revoked on the charge of unprofessional conduct and fraud in the practice of medicine.

In the past ten years, 1950-1960, we examined 6,369 applicants and licensed 5,096.

A great deal of time was spent working on the Revision of the Medical Practice Act that was presented to this session of the legislature. I will not go into detail as the Legislative Committee will give you a report on this and other legislation of interest to the medical profession that was presented to the legislature.

In 1960 the Division of Physical Therapy of the Board of Medical Examiners registered 33 physical therapists, 31 through endorsement and two through examination. We would like to remind those of you who hire physical therapists that registration is required.

"Resolution 61-15, Commendation of the Hillsborough County Medical Association and Woman's Auxiliary, is approved as presented.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-15

Board of Governors

Commendation—Hillsborough County Medical Association and Woman's Auxiliary

WHEREAS, the Florida Medical Association each year for a number of years has sponsored a health exhibit for the public in the Florida State Fair at Tampa; and

WHEREAS, by bringing medically authentic information to the public these exhibits have received high praise and brought favorable recognition to the medical profession; and

WHEREAS, the preparation and implementation of these exhibits necessarily must be carried out locally; and

WHEREAS, by reason of their location, the local medical association and its Woman's Auxiliary have been called upon year after year for assistance; and

WHEREAS, this necessary aid has been and continues to be furnished in a willing and highly capable manner; therefore be it

RESOLVED, that the Florida Medical Association express its official appreciation to the Hillsborough County Medical Association and to its Woman's Auxiliary in recognition of their invaluable service to the state association in the past, present and future in preparing and conducting the annual Florida State Fair Medical exhibit; and be it further

RESOLVED, that copies of this resolution be forwarded to the presidents and secretaries of the Hillsborough County Medical Association and the Woman's Auxiliary to the Hillsborough County Medical Association.

"The Presidential Address by Dr. Leo Wachtel is approved. Dr. Wachtel is commended for his unselfish devotion and service to the Association and the medical profession. His contributions to the progress of the Florida Medical Association and to the American Medical Association, particularly during the past year, will aid the future of medicine.

"Mr. Speaker, I move that the above be adopted and that Dr. Wachtel be commended by the Association."

Motion carried.

"Resolution 61-4 Medical Care Commission, is approved in principle and the committee recommends that it be referred to the Florida Medical Association Delegates to the American Medical Association House of Delegates.

"Mr. Speaker, I move the adoption of this report and the approval of the action of the Committee."

Dr. Holland: "At the time of the American Medical Association meeting in this hotel last year, a similar commission was appointed with Dr. Orr as it chairman. That commission has done a world of work, but has not yet had a chance to make a report. Dr. Chrisman, our other delegate, has checked with the American Medical Association and everything encompassed in this resolution is being carried out. I do not think you would want us to take this resolution to the American Medical Association at this time.

Dr. Frank C. Bone of Orange: "In view of what Dr. Holland said, I move that this resolution be tabled for one year."

Seconded by Dr. Cecil Peek of Palm Beach.

Motion carried.

Dr. Bielek: "Resolution 61-6, Emergency Medical Care, is approved in principle, and the Committee recommends that the following changes be made in order that it may be used by any county society when necessary: Delete the word "Duval" each time it appears and in its place use the word "each;" delete from the fifth paragraph the phrase 'in regular meeting on April 4, 1961.' The committee further recommends that this resolution be referred to the Judicial Council for use as a guide for future disciplinary actions.

"Mr. Speaker, I move the adoption of this portion of the report as amended and move the approval of the action of the Committee."

No discussion; no objections, motion carried.

Resolution 61-6

Emergency Medical Care

Duval County Medical Society

WHEREAS the basic responsibility for medical care of patients rests with the medical profession; and

WHEREAS the most vital part of said medical care is the care of the individual patient by the doctor or doctors of his choice; and

WHEREAS ideal patient-doctor relationships depend upon the availability of the desired doctor, or a satisfactory substitute, not only during regularly scheduled office hours, but at any time needed for an emergency; and

WHEREAS satisfied patients are among the best friends a physician can have at a time when friends are in dire need; be it therefore

RESOLVED, That each county medical society hereby remind its members of their obligations to their patients as stated in Section 1, Principles of Medical Ethics of the A.M.A.

"The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion," and be it further

RESOLVED, That each county medical society urge each of its members to see that he or she, or acceptable substitutes, are available for the emergency care of patients at all times, and be it further

RESOLVED, That members of the Society who are accused of consistent neglect of patients through repeated unavailability of doctor or substitute shall face charges of violation of Section 1 of the Ethics of Medicine, and be it further

RESOLVED, That a physician found guilty of such charges shall be subject to disciplinary action as the Society shall see fit, up to and including expulsion from membership.

"Mr. Speaker, I move the adoption of this entire report as amended."

No discussion; no objections, motion carried.

REPORT OF REFERENCE COMMITTEE No. IV

Legislation and Miscellaneous

Dr. Eugene B. Maxwell: "Your reference Committee No. IV met with all members present and gave careful consideration to items referred to it and makes the following report:

"The first portion of the report of the Council on Legislation and Public Agencies as printed in the Handbook, and the supplement which was

read at the first meeting of the House of Delegates are approved.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Legislation and Public Agencies

H. PHILLIP HAMPTON, *Chairman*

Members of the Council on Legislation and Public Agencies participated in congressional activities leading to passage of the Kerr-Mills Law and defeat of the Anderson amendment. Two members of the Florida Congressional delegation, Congressman Syd Herlong and Senator George Smathers, played key roles in these successful actions.

Dr. Edward Annis ably represented the American Medical Association at the Democratic National Convention and in TV debates with Sen. Hubert Humphrey and labor leader Walter Reuther, opposing the provision of federally administered medical care for all social security recipients financed by a compulsory social security tax.

Recommendations have been made to the Legislative Council and state organization of County Commissioners to implement the Kerr-Mills Law in Florida by creating a county, state and federal matching fund to pay for health services to the aged needy sick.

Members of the board and staff of the Department of Public Welfare have resented the intrusion of the Florida Medical Association in administrative affairs concerning medical care of public assistance recipients and because of these actions an open breach has developed between the Department of Public Welfare and the State Board of Health.

The primary interests of the Florida Medical Association in the 1961 session of the Florida legislature will be implementation of the Kerr-Mills Law in Florida and revision of the Medical Practice Act.

Supplemental Report of Council on Legislation

Nationally

The King Bill (the Administration's program for hospital and nursing home care for social security recipients) will be considered by the House Ways and Means Committee beginning in July. Thereby any move to enact this legislation by amendment rider in the Senate is thwarted.

Today, the President asked the Congress not to enact additional give-away programs in order to conserve and organize all available national resources behind the space program. I hope this sentiment will apply to King type legislation.

State

The House Welfare Committee of the Florida legislature has proposed a bill to implement the Mills-Kerr law in Florida creating the public assistance category of MAA (medical aid for the aged). It has little chance of passing and less of receiving an appropriation in this legislature.

The legislators and county commissioners have been convinced that such legislation would invite many elderly people to come to Florida for free medical care.

The Medical Practice Act revisions bill (House Bill 853) has passed the House and is on the Senate calendar for tomorrow after three public hearings and six amendments which have not been detrimental.

Amendments to the Hospital Service for the Indigent law (House Bill 1580) has passed the House and is on the Senate calendar for tomorrow. It authorizes treatment for cancer under this law and puts two county commissioners on the advisory board.

We hope to enlighten the county commissioners concerning implementation of the Mills-Kerr law through the provisions of Florida Hospital Service for the Indigent law and gain 100 per cent voluntary county participation in order to obtain the average 66 per cent reimbursement available to Florida for a large portion of the $21,000,000 now being spent annually by counties for health services to the indigent.

House bill 2161 authorizing the establishment of Professional Services Corporations passed both houses. It provides a means of tax savings for physicians that here-to-fore have been available only to corporation executives.

"The report of the Committee on State Legislation is approved as printed in the Handbook.

"Your reference Committee recommends that the Legislative Committee, in the future, notify members as early as possible of matters which are to be brought up in the Legislature, so that members may talk to their representatives.

"We wish to commend this Committee for its very successful legislative program this year, in which two of our major objectives were achieved —passage of the Medical Practice Act and the bill authorizing the establishment of professional services corporations.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on State Legislation

EDWARD R. ANNIS, *Chairman*

Your Committee on State Legislation is pleased to report that the Association's legislative program for the 1961 session of the Florida legislature consists primarily of the following major objectives:

1. Revision of the Medical Practice Act
2. Implementation of the Kerr-Mills Bill (Public Law 86-877) advocating support of adequate appropriation of state funds to provide health care for indigent citizens.
3. Support of legislation considered by the medical profession to be in the best interest of the public's health and welfare.
4. Active opposition to any and all legislation adversely affecting the practice of medicine and considered to be detrimental to public health and welfare.

Prior to convening of the legislature various legislative proposals to be sponsored by other organizations were carefully considered and acted upon. As done in the past, the Association will maintain an office under the direction of Mr. Alvin D. James, Director, Legislative Department, at the Cherokee Hotel, Tallahassee, during the entire 1961 session.

It is planned that a supplemental report will be submitted presenting the current status of all legislation of interest to the Association as introduced during the legislative session.

"On the report of the Subcommittee on Liaison with State Agencies, the Committee recommends approval of the following reports of the members of this subcommittee as printed in the Handbook.

Alcoholic Rehabilitation

Industrial Commission
Division of Mental Health
Children's Commission
Education Department
Crippled Childrens' Commission
Hospital Licensure

"Mr. Speaker, I move the adoption of this portion of the report."

Dr. Harry E. Beller of Dade: "I request that the report on the Industrial Commission be withheld at this time and be considered with another report which will come up later."

Motion approved except that action was postponed on Dr. Charles Larsen's report on liaison with the Industrial Commission.

Following are reports presenting the activities and recommendations of the various subcommittees serving under the Committee on State Legislation:

Subcommittee on Liaison with State Agencies

EDSON J. ANDREWS, *Chairman*

Alcoholic Rehabilitation

PAUL S. JARRETT

As a representative of the Alcoholic Rehabilitation Program on the Subcommittee on Liaison with State Agencies, it is my privilege to report that the Alcoholic Rehabilitation Program, with its hospital center at Avon Park, in cooperation with its network of outpatient clinics, has continued during this past year to promote treatment, education and research in the field of alcoholism.

We have been fortunate in retaining dedicated leadership in the program. An analysis of the program in the form of patient fate studies is being carried out to enable us to improve the program, which has commanded the respect and praise of similar progressive efforts throughout the United States and Canada.

Specific support of the Committee on State Legislation is sought on two counts. The first is that of a renewal or continuation of the financing of the Florida Alcoholic Rehabilitation Program through the special trust fund which is an earmarked percentage of a portion of the Alcoholic Beverage Tax for the coming biennium. Our budget is within the estimated annual income from the source.

The second request is for the provision of special authorization for the Alcoholic Rehabilitation Program to make limited grants from the trust fund unused reserve. We feel that special clinical and educational projects are now advisable. These projects would be self-terminating or self-limiting as far as regular or continued support by the state is concerned.

Examples of carefully selected needs which we feel we may be able to meet are:

1. The opening of an outpatient clinic for alcoholism in cooperation with an active citizens' committee in the Palm Beach area, and
2. Cooperation with the Health Education Program in Florida Public Schools, wherein tested knowledge will assist in effective emphasis on alcohol education.

I am informed that legislation will be introduced and more specific information made available on any of these points.

I hope that this information may be included in the annual report of the Committee on State Legislation of the Florida Medical Association.

Industrial Commission

CHARLES LARSEN JR.

The Subcommittee to the Florida Industrial Commission did not find it necessary to pursue any particular project during the past year. Although no meeting was held, there were numerous contacts with the Industrial Commission, especially regarding the Association's efforts in seeking revision of the Workmen's Compensation Fee Schedule. The results of our successful negotiations are reported in the annual report of the Committee on Industrial Medicine.

It is my firm belief that good liaison exists between the Association and the Commission and that continued efforts on the part of the Association to be of assistance should be maintained at the current high level.

Division of Mental Health

WILLIAM M. C. WILHOIT

During the past year, the Association's primary liaison with the State Division of Mental Health has been maintained by the Committee on Mental Health through its various acivities in conjunction with and affecting the state agency. It has been my privilege to serve as Chairman of that Committee. For a description of pertinent programs and activities, reference is directed to the annual report of the Committee on Mental Health which is included in the report of the Council on Medical Services. It is felt that the close relationship which exists between the Association and the Division has resulted in continuing, constructive improvements to Florida's mental health program.

Children's Commission

GEORGE S. PALMER

The Subcommittee on Florida Children's Commission, of which I am Chairman and sole member, has only general information to report concerning its activities during the past year. The Chairman attended a meeting of the Florida Co-operative Council in January 1961 in Tallahassee. This was called by the Children's Commission, and the purpose of this meeting was to discuss and make further plans for the 1961 legislative session. It was in the nature of a follow-up to the 1960 White House Conference on Children and Youth. The Florida Co-operative Council is composed of representatives of all organizations or individuals who are interested in the youth of our state. As a result of this meeting, 1961 legislative recommendations were formulated and put into print. A copy of these recommendations is on file. No one could really disagree with any of these concerns, but there is little likelihood of their translation into actuality in the near future because of the precarious financial condition of the state. In my opinion, the role and function of the Children's Commission is a rather nebulous one and not altogether practical. I would feel that there is much duplication of effort and activity with the many other state agencies concerned with children and youth. From the statements in the press recently, of several members of the legislature, it is my belief that the existence of the Children's Commission will be terminated. However, as long as the Children's Commission is functioning and is active, I believe that it is good to have a representative of our Association delegated as an interested observer and/or consultant.

Education Department

WARREN W. QUILLIAN

The Florida Medical Association has direct liaison with the State Department of Education, through the School Health Advisory Committee, which is actually the Association's Committee on Child Health. A meeting was held

with representatives of the Department of Public Health and the Department of Education in November 1960. There was considerable discussion in regard to the wide variation in quantity and quality of school health service in privately owned and parochial schools not coming under the jurisdiction of the state school health program (which is a fine one). During the past year the heavy influx of Cuban refugees, especially in Dade and Monroe Counties, has introduced many serious problems in this field. Governor Bryant was officially informed of this situation and was requested to seek ways and means for improving school health services in those primary and secondary schools in Florida which do not come under the responsibility of the State Department of Education and the State Board of Health.

Further implementation of the resolutions regarding support of Florida's school health program, passed by the Association's House of Delegates at the Annual Meeting of April 1960, was attempted by forwarding copies of these Resolutions to the president and secretary of each county medical society, with the request that these resolutions be distributed to the society membership.

Plans were discussed for evaluation of textbooks and health instruction methods used in Florida schools. Some of the books are outdated, and others may be medically inaccurate. The School Health Advisory Committee made known its availability to review such materials when requested by the two state agencies concerned.

In view of the obvious need for more complete immunization of school children in the state against infectious diseases, our Committee requested the formation of a joint study committee to evaluate Florida laws affecting immunization and to make necessary recommendations for new legislation or regulations in this field. The joint study group, composed of representatives from the State Board of Health, the State Department of Education and the Florida Medical Association, has been designated by proper authorities. No report from this group has yet been received.

The Subcommittee feels that much can be accomplished by continued efforts to work with other existing agencies charged with the responsibility of the health and education of our school children. The present relationship is a good one.

Crippled Children's Commission

FRED MATHERS

The Florida Crippled Children's Commission carried on its routine activities in a satisfactory manner during the past year. There has been an increase in the population of Florida and an increase in case loads for the commission. One new district was added under the direction of the orthopedic department of the University of Florida College of Medicine. The new districts that were planned in the areas of rapid population growth had to be held in abeyance because of lack of increase in the budget.

No new legislation is recommended at this time.

Hospital Licensure

WILLIAM W. RICHARDSON

It has been a pleasure for me to serve on the Advisory Hospital Council during the past year. I have attended the joint meetings of the council and the Florida State Board of Health. It is my impression from these meetings that the standards of hospitals in our state are definitely being raised. Since this licensure program has two facets, one of regulation within hospitals and the other of education toward better hospitals, it is felt that it is a worthwhile endeavor.

I have no specific recommendations to make at this time to the Florida Medical Association. It will be very helpful to me as a council member to receive any suggestions from members of the Association as to how we might further improve our licensure program.

"The report of the Committee on National Legislation, which includes the report of the Subcommittee on Liaison with Federal Agencies, is approved, including the following reports:

Department of Health, Education and Welfare

Department of Veterans Administration

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Department of Health, Education and Welfare

JERE W. ANNIS

Briefly, the Subcommittee on Health, Education and Welfare acted informally throughout the year in cooperation with your full Committee. The coordination of the Committee's activity in the meeting with the Congressional Representatives of our state, which took place in Washington on March 16, culminated the efforts on the part of the Committee to convince our Representatives that their continued support of the conservative approach toward questions of health, education and public welfare was essential to the country, as well as extremely important to our state. I think you will agree that, by and large, their reaction was most favorable and that we may be assured of their opposition to socialistic reform measures that are being introduced into the current Congress. Activities on behalf of defeating the Federal Aid to Education approach have been carried out, and responses have been good.

In addition to the foregoing, I have met regularly with the State Welfare Board as a member of it, and have, at its monthly meetings, endeavored to project our philosophy of local responsibility and obligations into its thinking. In this I have been successful only to a minor degree, and feel that there is an ever widening schism developing between the State Board of Health and the staff of the Department of Public Welfare. At the present time this is finally an overt and obvious breach, and can no longer be camouflaged.

The Staff of the Department of Public Welfare feels that the financing of the Medical Assistance to the Aged program should be limited to state and federal funds, since they wish to be all-important and omnipotent in the administration of the program which they would like to be unaffected by opinions and data derived at a local level. The Board is divided in its feelings in this matter and I have tried to sway the members toward the principle and theory of local participation. I am afraid that I have been unsuccessful in this attempt.

Finally, I think that the Association has been individually and collectively active in the matters of health, education and welfare on a local and national scale, that it has perhaps accomplished little more than a holding action, but that this activity must be encouraged in the future if we are to retain any possible hope of reasserting the dominance of our system of free enterprise and initiative.

Department of Veterans Administration

ROY E. CAMPBELL

During the past year the Committee on Veterans Care has been active in several aspects of this field. We have been in contact with the medical director, Dr. Earp, and have been able to negotiate several misunderstandings between members of the Florida Medical Association and the Veterans Administration. The services of the Committee were offered to Dr. Earp, and he has been very

happy to refer us any case which requires cooperation.

One problem which was satisfactorily settled was the procurement of x-ray reports on veteran patients from hospitals rather than from the radiologist. Through Dr. Earp's cooperation, all veterans facilities were advised that in the future these reports would be obtained only through a private radiologist.

Another case in which the Committee was active was the case involving the prescription of Metrecal by a physician to a veteran patient. The physician was later billed for the $98.00 worth of Metrecal by the Veterans Administration, which stated that this was a nonprescribable foodstuff, and it was the doctor's responsibility for payment after he had prescribed it. Only after referring the matter to the Florida Medical Association lawyers was the Veterans Administration willing to recognize the fact that it was not necessarily the doctor's obligation to pay for either medication or foodstuffs prescribed for veterans.

It has been a pleasure to work with the members of the administrative staff of the Florida Medical Association in reference to these problems. They have been most helpful and cooperative.

"The report of the Council on Medical Economics includes several reports which will be considered individually.

Council on Medical Economics

FLOYD K. HURT, *Chairman*

The Council on Medical Economicshas during the past year directed and supervised the activities of the Florida Medical Association concerning all matters of medical economics affecting the membership. The major duties and functions of the Council were to maintain liaison with Blue Shield of Florida and commercial health insurance agencies, to advise on industrial medicine relations and contracts with state and federal agencies, and to serve as a clearing house for review of all fee schedules approved by the Association. Following are annual reports outlining the activities and recommendations of those Committees serving under the Council.

"The report of the Committee on Advisory to Blue Shield is approved with the following amendments:

"The Reference Committee approves the recommendation of the Board of Governors at its meeting on April 8, 1961, that representatives of commercial health insurance carriers be asked to participate and made a part of the liaison committee to concern themselves with the costs of medical care in Florida. This refers to the last paragraph of the report in which it is recommended that efforts be made to form a liaison group consisting of representatives of the Florida Medical Association, the Florida Hospital Association, the Blue Shield Board of Directors and the Blue Cross Board of Directors to concern themselves with the cost of medical care in Florida.

"We also recommend that the President-Elect of the Florida Medical Association, or his duly appointed representative, be made an ex officio member of the Blue Shield Board of Directors, and that the President of Blue Shield, or his duly appointed representative, be invited to attend meetings of the Florida Medical Association Board of Governors.

"Mr. Speaker, I move the adoption of this report as amended."

No discussion; no objections, motion carried.

Committee on Advisory to Blue Shield

RALPH M. OVERSTREET JR., *Chairman*

During the year, the Association's Advisory Committee to Blue Shield (Committee of Seventeen) had two full committee meetings and a two day informational meeting with the Blue Shield Board of Directors.

This Committee worked with the Blue Shield New Contracts Committee and Board in preparing the final "K" Contract, which is now being sold in the state and is being well received as a replacement for the old "J" Contract. The "K" Contract is the $4,000 low level federal employee contract which was approved by the House of Delegates in 1960 for sale to the general public.

Your Committee has recommended to the Board of Governors that a new Blue Shield contract be written including service benefit provisions for families with annual incomes up to $6,000, the fees to be based on relative values and the same level of fees as is in the high option federal employees contract now available to federal employees in Florida.

The Committee is favorably considering the recommendations of the Blue Shield Board on a special contract for people over 65 and an outpatient diagnostic rider for laboratory and x-ray services. Both these coverages were recommended by the House of Delegates of the Florida Medical Association.

The Committee recommended to the Board of Governors that efforts be made to form a liaison group consisting of representatives of the Florida Medical Association, the Florida Hospital Association, the Blue Shield Board of Directors, the Blue Cross Board of Directors, and representatives of commercial health insurance carriers to concern themselves with the cost of medical care in Florida. This would parallel the efforts of the national associations of those same groups.

"The report of the Committee on Commercial Health Insurance is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Committee on Commercial Health Insurance

DUNCAN T. McEWAN, *Chairman*

A joint meeting of the Florida Medical Association Committee on Commercial Health Insurance and representatives of the Florida Health Insurance Council was held in the Hotel Robert Meyer in Jacksonville on January 14.

The purpose of this meeting, as stated by the respective committee chairmen, was to discuss areas where the medical profession and the insurance industry could make changes and improvements and initiate educational programs to aid one another and improve service to the patient. Various types of abuse of health insurance, such as excessive fees, unnecessary hospitalization, protraction of disability, padding of surgical and medical charges to offset deductibles, and excessive and prolonged treatment were discussed. Case experiences from claim files were also described. Among the insurance company abuses discussed were multiple coverages, unrealistic coverage, agent misrepresentation and delay in payment of claims.

Through the cooperative efforts of the Committee and the Florida Health Insurance Council, administrative machinery has been established to aid in resolving areas of misunderstanding between physicians, insurance carriers and other parties involved in voluntary health insurance matters.

It was agreed that complaints made against physicians are to be directed first to the state level committee (the Association's Committee on Commercial Health Insurance) for referral to the Insurance Committee or other appropriate committee of the county medical society concerned and then, if necessary, back to the state level committee. Complaints from physicians regarding practices of insurance companies are to be directed to the Florida Medical Association for forwarding to the chairman of the Medical Relations Committee of the Florida Health Insurance Council for investigation and disposition. This recommended method for handling abuses of health insurance and ill-advised practices of insurance companies permits both physicians and companies recourse to impartial evaluation.

A new form entitled "Attending Physician's Statement" proposed by the Health Insurance Council was reviewed, and it is the recommendation of this Committee that it be approved by the House of Delegates.

"There was a great deal of discussion about the report of the Fee Schedule Committee, which tied in very closely with the report of the Committee on Industrial Medicine, and we would like to consider these reports jointly.

"It is the recommendation of your Reference Committee that the Report of the Committee on Industrial Medicine be approved with the following amendments:

"It is recommended to the Board of Governors of the Florida Medical Association that all inquiries, communications, complaints and recommendations concerning the newly adopted Workmens' Compensation Fee Schedule be first directed to the appropriate committee of the Florida Medical Association, and

"That the Industrial Commission be requested likewise to refer all communications received from individual physicians and interested specialty groups to the Florida Medical Association for processing through the appropriate committee, and

"That all members of the Florida Medical Association be informed of this action.

"That, because of gross inequities that are now realized in the new Workmen's Compensation Fee Schedule, which inequities have stimulated numerous complaints, preparation for petitioning the Industrial Commission be initiated immediately following the completion of the first full year of operation under the new schdeule, which will be September 1, 1961, and

"That, in renegotiation of this schedule, special attention be given to those groups who believe that the schedule is inequitable, especially the Dermatologists and Anesthesiologists, and

"That, in petitioning for renegotiation of the fee schedule that the appropriate committee of the Florida Medical Association utilize the talents of any and all members who may be beneficial.

"And, it is also our recommendation that the Workmen's Compensation Fee Schedule should not be offered as a service contract and that the Compensation Law as it now reads with regard to average fees in the same community for persons of similar standards of living should prevail and that more leeway for A. & A. be included."

Dr. Beller suggested that every specialty group should be included in the negotiations.

Dr. Day explained that this was already incorporated by a change in the By-Laws which requires the Fee Schedule Committee to consult with the Council on Specialty Medicine.

Dr. Babers: "I want to be sure that I understand what you mean. I feel surely that every group should be thoroughly represented. However, in the actual negotiations, I doubt if it would be wise to take an army up there with us. Therefore, I hope what you mean is that every specialty has a chance to express itself, and that we know what you want when we do get ready to negotiate.

"Secondly, I am sure this will require real solid preparation in a number of fields and I doubt that we will be ready to do this by September 1. I take it that you do not expect us to do it on that date, but want us to get to work."

The Speaker asked Dr. Babers if he was in favor of the amendments offered by the Reference Committee and he replied in the affirmative.

The Speaker then asked for a voice vote on the report of the Committee on Industrial Medicine as amended and the Committee on Fee Schedules, which carried.

Committee on Industrial Medicine

CHARLES LARSEN JR., *Chairman*

The Committee is pleased to report that after several conference sessions with representatives of industry, negotiations were successful in obtaining an upward revision of the Medical and Surgical Fee Schedule for Workmen's Compensation Cases. Revision of the Workmen's Compensation Fee Schedule was accomplished by use of the relative value schedule as officially approved by the House of Delegates of the Florida Medical Association. By order of the Florida Industrial Commission, the revised fee schedule was made effective September 1, 1960, and subsequently fees applicable to certain eye procedures have been approved as an addendum to the schedule.

Following adoption and application of the newly revised fee schedule certain problems have arisen which the Committee believes should be adjusted. Several of the problem areas have already been called to the attention of the Industrial Commission. In this regard specific reference is made to the inequity regarding a charge for

an initial office visit when a fee for surgical procedure is also made. For instance, when a private patient consults a physician for an elective procedure, the usual practice is to charge for an office consultation. Preoperative care begins when an operation has been agreed upon or authorized. The commission is of the opinion that in the case of an emergency operation in which definitive treatment is a part of the initial care, a physician is entitled to the surgical fee for a procedure made necessary by the compensable accident and is not entitled to collect a fee for the first office visit in connection therewith. The commission has ruled that all fees for surgical procedures include first office visit since same consists of preoperative care. The Committee does not concur in this arbitrary ruling, namely because the management of an elective case would warrant an initial office visit, whereas in emergency cases an initial office visit may not be a justifiable charge.

Another area of concern involves cases of minor surgery performed in the physician's office in which fees in the range of $13.00 are provided. Here the divergence of opinion illustrates the fallacy of using part of the provisions of a contract drawn for one purpose (Blue Shield Type "A") and applying it to another (Workmen's Compensation) drawn for an entirely different purpose. At the numerous conferences with industry, physician members of the committee repeatedly pointed out that the Blue Shield contract is a limited service contract. Its provisions are intended in part to limit Blue Shield's liability to the policyholder, allowing the doctor to make additional charges. In contrast, the Workmen's Compensation Fee Schedule is a complete service contract under which the doctors of Florida have agreed not to charge the patient or employer an additional fee except in the most unusual circumstances.

The Workmen's Compensation Fee Schedule was revised by using the relative value schedule upon which the Blue Shield "A" Contract was developed; however, the Florida Relative Value Schedule does not include any postoperative care for certain procedures. The reason is that in most minor office procedures the amount of such care is so extremely variable that determination of an average fee was not feasible. Unfortunately, this is not spelled out in the Blue Shield Manual and has understandably confused our Workmen's Compensation program.

The Committee further feels that if revision made in the anesthesiology fee schedule should result in actual decrease in fees over the archaic 1938 and 1952 schedules, then equitable changes should be made.

Having experienced the difficulty of revising a schedule which had not been changed for a period of eight years (1952-1960), the Committee concurs in the recommendation that the Workmen's Compensation Fee Schedule remain under continued surveillance and that revision be sought at the maximum of every two year period.

Your Chairman wishes to express his personal appreciation for the time and interest displayed by those physicians who so generously gave of their time and efforts in serving on the Committee.

(The following seven paragraphs were added by the Reference Committee.)

It is recommended to the Board of Governors of the Florida Medical Association that all inquiries, communications, complaints and recommendations concerning the newly adopted Workmen's Compensation Fee Schedule be first directed to the appropriate committee of the Florida Medical Association, and

That the Industrial Commission be requested likewise to refer all communications received from individual physicians and interested specialty groups to the Florida Medical Association for processing through the appropriate committee, and

That all members of the Florida Medical Association be informed of this action.

That, because of gross inequities that are now realized in the new Workmen's Compensation Fee Schedule, which inequities have stimulated numerous complaints, preparation for petitioning the Industrial Commission be initiated immediately following the completion of the first full year of operation under the new schedule, which will be September 1, 1961, and

That, in renegotiation of this schedule, special attention be given to those groups who believe that the schedule is inequitable, especially the Dermatologists and Anesthesiologists, and

That, in petitioning for renegotiation of the fee schedule that the appropriate committee of the Florida Medical Association utilize the talents of any and all members who may be beneficial.

And, it is also our recommendation that the Workmen's Compension Fee Schedule should not be offered as a service contract and that the Compensation Law as it now reads with regard to average fees in the same community for persons of similar standards of living should prevail and that more leeway for A. & A. be included.

Committee on Fee Schedules

ROBERT E. ZELLNER, *Chairman*

The Committee on Fee Schedules is a new committee created by the House of Delegates when it adopted the new Charter and By-Laws at its 1960 Annual Meeting. The Committee is charged with negotiating in conjunction with appropriate other committees any and all fee schedules approved by the Association and with keeping the Florida Relative Value Schedule of Medical and Surgical Procedures both up to date and relative. The only fee schedule adopted by the Association in the past year was the Workmen's Compensation Fee Schedule. Since negotiations were under way through the Committee on Industrial Medicine before the inception of this Committee, the latter Committee continued to carry the load in these negotiations. The Committees on Fee Schedules and on Industrial Medicine worked in complete harmony, however, in obtaining what was certainly the most favorable Workmen's Compensation Fee Schedule that it was possible to get at this time. For this, Dr. Charles Larsen, Chairman of the Committee on Industrial Medicine, deserves a resounding vote of thanks from the members of the Association.

The use of relative value schedules in constructing fee schedules is something new to Florida. Although the Medicare schedule is now five years old and the Blue Shield "A" Contract three years old, neither of these contracts affected a sufficient number of physicians in Florida to excite much comment.

The relative value schedule adopted by the House of Delegates is the one proposed by the Committee of Seventeen in 1957 as a basis for the Blue Shield "A" Contract fee schedule. This relative value schedule was the result of a statewide survey plus the advice of various specialty societies and the use of the 1957 California Relative Value Schedule. The Committee on Fee Schedules decided at the outset on several working principles:

1. It would begin to work forthwith in fulfilling its assigned task of keeping the relative value schedule up to date and consistent with actual practice in Florida.

2. It would seek the advice and assistance of each medical organization recognized by the Florida Medical Association as a representative of one segment of the medical profession.
3. No changes in the relative value schedule would be recommended unless the need for the change was clearly demonstrated and adequately documented. When a relative value is needed for a procedure done only or very largely by a limited specialty group, this information could be obtained from the appropriate specialty organization. When it concerned a large number of physicians, it could only be obtained by general survey.
4. It would not recommend a general survey even for a limited number of procedures until some experience had been obtained with the use of the present schedule.

In the fulfillment of the first two principles letters were written to those organizations representing general practice and the various medical specialties asking for their opinions as to the adequacy of the relative value schedule and for suggestions for modifications and changes. Replies were received from approximately one half of these organizations, and several presented detailed fee schedules studies.

The Committee met for two days in Jacksonville on January 14 and 15, 1961. At the first day's meeting, representatives of the Florida Society of Anesthesiologists were heard in their complaints about anesthesia fees in the new Workmen's Compensation Fee Schedule. Since there was no general agreement among the anesthesiologists present as to how the complaints should best be handled, it was decided that recommendation of this section by the Industrial Commission should be deferred until further information had been obtained from the Florida Society of Anesthesiologists. It was recommended to the Board of Governors that the inadequacy in the fees allotted for anesthesia for herniorrhaphies be brought to the attention of the Industrial Commission's office on an informal basis and an effort be made to correct this as an administrative affair. Certain changes in the relative values for anesthesia as applied to hernioplasties were recommended and approved.

On the next day the Committee met jointly with the Council on Specialty Medicine. Members of the Committee presented to members of the Council background information about the Committee and the use of relative values in fee scheduling; and then each member of the Council was asked to discuss, in general, matters of concern to this Committee and peculiar to his specialty.

At a subsequent meeting it was brought up that while the Florida Relative Value Schedule has only four sections and should have a conversion factor for each, there were two conversion factors for the surgical section, one for surgery and one for anesthesiology. It was felt that this is a mistake which should be corrected.

Recommendation 1: That those fee schedules now in use and in which this discrepancy exists (Blue Shield high and low level Civil Service Contracts, "A" and "K" Contracts and the Workmen's Compensation Fee Schedule) be brought into conformity with this policy as soon as practical.

Consideration was given to the relatively small size of the Committee on Fee Schedules, and it was the opinion of the Committee that it could operate more effectively if the number of its members was increased from five to nine. This Committee faces a situation similar to that confronting the Committee of Seventeen at its inception in that not only does it need to have the understanding and support of the preponderance of the doctors of Florida, but it also has an education to acquire. The possible annual loss of two of the five members of the Committee could seriously hamper its effectiveness. The addition of one more member for each medical district would not only provide for greater continuity of work, but could also provide for better geographic distribution of representation on the Committee.

Recommendation 2: That an additional member from each medical district be named to the Committee on Fee Schedules.

Because of the close relationship which must necessarily exist between the Council on Specialty Medicine and the Committee on Fee Schedules, consideration was given to the composition of the Council. The Council as presently constituted has two functions: To provide a means of liaison between the Association and specialty organizations within the state and to provide a vehicle through which various medical specialties may represent their fee schedules. These two functions are not completely consistent, in that in the one case organizations are represented and the other medical specialties are. In highly organized specialties such as surgery, many organizations representing one interest may be entitled to membership on the Council, leading not only to confusion but to duplication. With regard to fee scheduling it is important that each medical *specialty* have a voice in the Council.

Recommendation 3: That consideration be given to reconstituting the Council on Specialty Medicine in such fashion that insofar as its relationship to the Committee on Fee Schedules is concerned each specialty will have only one representative on the Council.

Inconsistencies in the ear, nose and throat section of the relative value schedule were brought to the attention of the Committee by the Florida Society of Ophthalmology and Otolaryngology. This society presented detailed studies which were submitted to actuarial and statistical analysis by Blue Shield. As a result of these studies, the Committee recommended to the Board of Governors that certain changes in the relative value schedule be made in the aforementioned section.

Recommendation 4: That authorization be granted to publish the Florida Medical Association Relative Value Schedule, that one copy of the schedule be sent free of charge to each member of the Association, and that copies be made available at suitable charge to insurance companies and other interested parties.

The Chairman wishes to thank the members of the Committee, Mr. Alvin D. James of the Florida Medical Association office and Mr. W. J. Stansell of Blue Shield for their help and their interest in the work of the Committee.

Dr. Maxwell: "The last paragraph of the report of the Committee on Members Insurance states that negotiations are nearing completion for a plan of professional liability insurance coverage for Association members. Since this report was written, on May 25, 1961, the Board of Governors has approved a plan of professional liability insurance for members offered by Marsh & McLennan and we recommend that this information be added to the report.

"Mr. Speaker, I move the adoption of this report as amended."

No discussion; no objections, motion carried.

Committee on Members Insurance

FLOYD K. HURT, *Chairman*

The prime concern and major responsibility of your Committee on Members Insurance is to maintain a continuing program of investigation and research to ascertain any new developments in the "state of the art" which could, if appropriate, be incorporated in the various coverages. In this way, we endeavor to keep the coverages among the finest on the market, yet underwriting these changes in a manner that will not result in adverse claim experience that could upset the stability of the various programs.

The changes introduced during 1959-1960 are:

DISABILITY INCOME PROTECTION

1. The policy has been amended without premium charge to provide for an extra payment of 50% of

the weekly indemnity while hospitalized, but not to exceed 10 consecutive weeks for any one accident or sickness. This Amendment was installed on February 1, 1960, and made retroactive to August 1, 1959.

2. Insured persons under age 55 may now apply for increased weekly indemnity up to $150 (plus 50% additional while hospitalized).
3. The total limit of insurance was increased. The Continental Casualty Company will now participate with other insurance companies to a maximum of $1,900 monthly any one doctor; will write up to $1,300 monthly any one doctor through the Florida Medical Association and other such association programs; and will write up to $1,500 total (association and individual policies) any one doctor; former limits were $1,500, $800, and $1,100 respectively.

OFFICE OVERHEAD EXPENSE

1. Effective March 1, 1960, all policies of Florida Medical Association members who are insured for "Office Overhead Expenses while disabled" have been broadened in that the limiting figure of 75% of average expenses has been voided. Insureds under this program may now recover up to 100% of their average of continuing insured expenses for the preceding six months.

CATASTROPHE HOSPITAL-NURSE EXPENSE

1. The Continental Casualty Company will allow doctors who reach age 70 to convert this coverage to their "5,000 Reserve" program, within 31 days of their seventieth birthday. This program is generally available to all persons over age 65, but this conversion privilege allows doctors to go in at any time during the year, rather than limiting them to the one month per year that is normal. Additionally, any doctor may, within 31 days of his sixty-fifth birthday, obtain coverage under the "65 Plus" program of the Continental Casualty Company; normally there is only one month in the year when this coverage is opened to additional persons. Doctors may have both of these plans if desired, the "65 Plus" after their sixty-fifth birthday and the "5,000 Reserve" after they are no longer eligible for Catastrophe Hospital-Nurse Expense coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT

1. There were no significant changes in this program during the year.

Additional Proposed Changes.—Through the very able assistance of our insurance administrators, the firm Marsh & McLennan, several additional changes in the Association-sponsored programs have been proposed and are to be considered by the Committee. Should the proposed changes receive favorable consideration prior to the Annual Meeting, a supplemental report will be submitted.

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Professional Liability Insurance.—Another area of concern to the Committee is to continue our effort towards eventual development and implementation of a sound program of professional liability insurance coverage for Association members. Past efforts have proved unsuccessful in negotiating a program acceptable to insurance companies and at the same time considered to be in the best interest of Association members. Currently, negotiations are nearing completion, and it is proposed that a supplemental report will be submitted outlining the progress made.

The Board of Governors, at its meeting on May 25, 1961 approved a plan of professional liability insurance offered by Marsh & McLennan.

"The report of the Medicare Mediation Committee is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Medicare Mediation Committee

BURNS A. DOBBINS JR., *Chairman*

During the calendar year 1960, this Committee met seven times and has held three meetings so far in 1961. One was held at the County Health Department Building in Gainesville, two at the Hotel Robert Meyer in Jacksonville and the remainder at the Florida Medical Association Building in Jacksonville. Attendance has been excellent.

Blue Shield paid 8,653 claims for a total of $727,548.70 during the calendar year. Of these 330 were considered by the county and state Medicare committees or 3.8% of the total claims paid. Florida's unique system of county committees, to which special reports and questionable claims are referred first, has proved even more valuable. The local committee is able to discuss the case with the physician, examine hospital and operating room records, if necessary, and furnish information on which the state committee can make an equitable decision.

Since benefits were restored on January 1, 1960, with the exception of the permit system for dependents living with their sponsors, the program has settled down considerably. Very few claims have been disapproved during the year; those that were disallowed were mostly "E" procedures (principally sterilizations) or home or office visits for medical cases, which are the responsibility of the patient.

Although the total amount paid by Medicare was lower this year, more physicians participated, 1,645, which is 81 more than last year.

The members of this Committee have spent many hours considering claims, both in and out of Committee meetings. The Committee is comprised of: J. Maxey Dell Jr. of Gainesville, Frank B. Hodnette of Pensacola, Vincent P. Corso of Miami, Kenneth G. Gould of Tampa, J. Brooks Brown and Emmet F. Ferguson Jr. of Jacksonville, John D. Milton of Coral Gables, Advisory, and Burns A. Dobbins Jr. of Fort Lauderdale, Chairman. The Committee is grateful for the fine cooperation and assistance of Mr. N. G. Johnson, Medicare Coordinator from Blue Shield, and Mr. Alvin D. James and Mrs. Mae Mason of the Association's office.

Again it is the recommendation of the Medicare Mediation Committee that the Florida Medical Association continue to cooperate in caring for the medical needs of the dependents of the Armed Services and extend its contract with the Office for Dependents' Medical Care. Only by so doing can we represent and protect the interests of approximately 1,700 members who participate in the program, settle differences on the local and state level rather than having them aired in Washington, and maintain good public relations with the many dependents of service men who live in our state.

"The reports of the Committees under the Council on Special Activities were approved as follows:

"Committee on Advisory to Woman's Auxiliary of the Florida Medical Association

"Committee on Board of Past Presidents

"Committee on Delegates to the House of Delegates of the American Medical Association

"Committee on Liaison with County Medical Societies

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Special Activities

WILLIAM C. ROBERTS, *Chairman*

The Council on Special Activities begs to make the following report:

Committee on Advisory to Woman's Auxiliary to the Florida Medical Association

GORDON H. IRA, *Chairman*

This Committee, with Dr. Gordon H. Ira as Chairman, reports that its chief activity this year consisted of attending the Fall Board Meeting of the Auxiliary in Sarasota on October 18 and 19. The Chairman was not able to attend the meeting due to the serious illness of his father in Nebraska. His place was ably taken by Dr. Lee Rogers Jr., who spoke to the Auxiliary, particularly with reference to some items that our President, Dr. Wachtel, was especially interested in.

One of these items was the insurance program sponsored by the Association. The point was stressed that the Auxiliary members were not to endeavor to sell the policies, but to see that their husbands were informed about them. The first was the Income Protection Policy against accident and sickness, the second the Accidental Death Insurance, the third a Catastrophic Hospital Policy, and the fourth the Overhead Office Expense Protection Policy.

Another item emphasized was participation as individuals in the Florida Medical Committee for Better Government.

The Chairman received a letter from Mrs. John M. Butcher, President of the Auxiliary, stating that Dr. Rogers' talk was the highlight of the Fall Board Meeting. Dr. Rogers is commended and thanked by the Association as well as the Auxiliary for this fine effort and contribution.

Committee on Board of Past Presidents

SHALER RICHARDSON, *Chairman*

The Board of Past Presidents remains in status quo from last year. The only exception is the welcome addition to the membership of the immediate past president, Dr. Ralph W. Jack. The Board continues to express and exhibit a keen interest in all things pertaining to and affecting the Association as well as organized medicine in general.

Committee on Delegates to the House of Delegates of the American Medical Association

REUBEN B. CHRISMAN JR., *Chairman*

The delegates to the House of Delegates of the American Medical Association report only one important item of interest in addition to routine matters of delegates to the American Medical Association. Our delegates are planning on nominating Dr. Homer L. Pearson Jr. to the Board of Trustees of the American Medical Association at the coming meeting in New York. Dr. Pearson deserves the backing of every delegate from every state in this endeavor.

Report of Delegates to the House of Delegates Of the American Medical Association

The Florida Medical Association was represented by its four delegates to the American Medical Association at the annual meeting held in Miami Beach in June 1960, and at the Clinical Session, held in Washington, D. C., the week of November 28, 1960. The comprehensive report of these meetings was published in the August 1960 and January 1961 issues of The Journal of the Florida Medical Association. The AMA News also provided each member of the Florida Medical Association with a summary of these two meetings.

It is particularly noteworthy that the June meeting in Miami Beach marked the first time an annual meeting of the American Medical Association had been held in the state of Florida, and at that meeting, the retiring President, Dr. Louis M. Orr of Orlando, had the distinction of being the first member of the Florida Medical Association ever to fill that exalted post. Likewise, a notable event of the Washington Clinical Meeting in late November was the choice of a Florida physician for a signal honor. Upon nomination by the Florida Medical Association, the Board of Trustees and House of Delegates of the American Medical Association named Dr. James T. Cook Jr. of Marianna as the 1960 General Practitioner of the Year.

Several members of the Florida Medical Association are currently active in the affairs of the American Medical Association in an official capacity. These include Drs. Edward R. Annis of Miami, Chairman of the Speakers Bureau; H. Phillip Hampton of Tampa, Member of the Committee on Indigent Care; Burns A. Dobbins Jr. of Fort Lauderdale, member of the Committee on Federal Medical Services; Francis T. Holland of Tallahassee, Member of the Council on Rural Health; Edward H. Williams of Miami, Member of the Committee on Aging; Louis M. Orr of Orlando, Chairman of the Commission on the Cost of Medical Care; Ralph S. Sappenfield of Miami; Alternate Delegate to the Section on Anesthesiology; Homer L. Pearson Jr. of Miami, Chairman of the Judicial Council; and Reuben B. Chrisman Jr. of Coral Gables, Member of the Council on Legislative Activities, Member of the Council on Medical Service, and Member of the Committee on Maternal and Child Care.

The Board of Governors of the Florida Medical Association has approved the nomination of Dr Homer L. Pearson Jr. for election to the Board of Trustees of the American Medical Association. It will be the privilege of your delegates to place the name of Dr. Pearson in nomination for this office at the forthcoming Annual Meeting in New York City in June. Further, it will be their distinct pleasure to do all within their power to assist in elevating Dr. Pearson to this position of high responsibility which he so richly deserves. It is felt that, if elected, he will be a strong addition to the Board of Trustees of the American Medical Association.

The delegates, and Dr. Pearson, met with the Council on Medical Education and Hospitals of the American Medical Association. It is in sympathy with the directive from the House of Delegates of the Florida Medical Association regarding the infiltration of nonmedical personnel in medical education, but there are not enough doctors of medicine who are qualified to teach the basic sciences and are willing to teach them. It is, therefore, necessary that the teaching positions in these sciences be filled with instructors holding Ph.D. degrees.

The delegates have earnestly sought throughout the year to represent and promote actively the views and policies of the Florida Medical Association, and will continue to fulfill the duties and obligations as your official spokesmen in the House of Delegates of the American Medical Association.

Francis T. Holland
Meredith Mallory
Burns A. Dobbins Jr.
Reuben B. Chrisman Jr., Chairman

Committee on Liaison with County Medical Societies

WILLIAM C. ROBERTS, *Chairman*

The Committee on Liaison with County Medical Societies reports that several county medical societies were visited during the year in connection with socioscientific meetings and the Blue Shield Program.

The Societies as a whole realized their importance in organized medicine, but some of the societies are weak from an individual membership standpoint. Much greater emphasis must be given the individual or "grass roots"

members on the importance of their participation in the affairs of organized medicine if we are to continue to combat and conquer the many encroachments that tend to destroy the medical profession as we know and wish it to be. Much more emphasis must be placed on the realization of the truth in the axioms: "There is strength in union" and "Together we stand and divided we fall."

"It is our recommendation that Resolution 61-9 on Aged Indigent Care Through Blue Cross-Blue Shield Financed by Funds from Kerr-Mills Legislation be referred jointly to the Committee on Advisory to Blue Shield and the Committee on State Legislation for further study.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-9

Aged Indigent Care Through Blue Cross-Blue Shield Financed by Funds From Kerr-Mills Legislation

Duval County Medical Society

WHEREAS free medical care in our country has been rendered by physicians traditionally on the basis of need; and

WHEREAS some labor leaders, some politicians, socialists, and others are seeking to upset this tradition by asserting this to be a right of the individual and by not recognizing the fact that it is a privilege granted the needy as a responsibility of society; and

WHEREAS the Kerr-Mills Medical Aid for the Aged Law passed by the 86th Congress has not yet been given an adequate opportunity to function; and

WHEREAS the Florida legislature must implement the Kerr-Mills Law by passing proper legislation if Florida is to participate; and

WHEREAS adequate actuarial studies are not available for the care of the aged, the indigent, or the indigent-aged under programs of insurance, except for a two year study made in Colorado; and

WHEREAS the Colorado experience with modifications may prove to be financially and professionally satisfactory for all concerned; therefore be it

RESOLVED, That the Duval County Medical Society endorse the immediate, early, realistic implementation of the Kerr-Mills Law by the Florida legislature; and be it further

RESOLVED, That the State of Florida and the Blue Cross and Blue Shield of Florida be requested to investigate the aforementioned study, toward the end that it may be included in the Blue Cross-Blue Shield plans with low cost service provisions financed by the Kerr-Mills Law on a cost basis; and be it further

RESOLVED, That the delegates from the Duval County Medical Society to the 1961 House of Delegates of the Florida Medical Association be instructed to convey this resolution to that body and to seek endorsement and early implementation of its principles by it.

"Resolution 61-10 on Sterilization is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-10

Sterilization

Bay County Medical Society

WHEREAS there is oftentimes a real need to permanently sterilize a human being in Florida; and

WHEREAS there is no law in Florida to govern or give permission to perform this procedure regardless of the indication, which is usually known as a permissive act; and

WHEREAS those who might perform this procedure are subjecting themselves to the mercy of the "Maime Act" in the event of litigation therefrom; and

WHEREAS there should be on the statute books of Florida a permissive act to sterilize human beings so that one who performs this procedure will know the law, be protected or prosecuted thereby, and be governed accordingly; and

WHEREAS the Florida Medical Association has a legislative committee which could compile such an act according to the thinking of the committee and propel it through the state legislature into law; be it therefore

RESOLVED that the Bay County Medical Society ask and request the Florida Medical Association through its legislative committee to make every effort to get such legislation accomplished.

Note: The above resolution was passed by the Bay County Medical Society in regular session this 7th day of March nineteen hundred sixty one A. D.

"Resolution 61-14 on Communications is approved as presented.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-14

Communications
Board of Governors

WHEREAS the practice of medicine is constantly undergoing change; and

WHEREAS medical research is more complex, more extensive and possibly more productive than ever before; and

WHEREAS the organization of specialty societies has concentrated the professional interest of many physicians; and

WHEREAS the demands of a physician's time seem to constantly increase; and

WHEREAS the printed page has reached the saturation point; and

WHEREAS the multiplicity of meetings and the complexities of medicine make medical communication more necessary and more available yet less assimilated by the average practitioner, therefore be it

RESOLVED that the Florida Medical Association endorses the idea of a commission on communications to be organized on a national level to investigate the field of medical communication; be it further

RESOLVED that such a commission be made up of experts from all fields of communication (medical and otherwise), and with the anticipated goal of determining how to reach the vast majoriy of medical doctors in all fields of practice; be it further

RESOLVED that the Florida Medical Association's delegates to the American Medical Association House of Delegates be instructed to promote the organization of this commission by that body.

"It is recommended that Resolution 61-17 on Blue Shield, which dealt with a $25 deductible Blue Cross policy and the elimination of claims for $10 or less in the Blue Shield contract, be

referred to the Committee on Advisory to Blue Shield.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-17
Blue Shield
Escambia County Medical Society

WHEREAS there has been a steady increase in premiums of Blue Cross and Blue Shield policies; and

WHEREAS Blue Shield of Florida is attempting to give better coverage by closing out the J Blue Shield by conversion to the K Blue Shield; and

WHEREAS to buy the K Blue Shield contract, it is necessary to buy the Blue Cross 2J or 5J policy with a total premium outlay for a family of $43.05 quarterly, with Blue Cross receiving $24.45 and Blue Shield $18.60; and

WHEREAS the increased premiums are becoming out of range of the low economic group; and

WHEREAS it costs as much for Blue Shield and Blue Cross to process a $10.00 claim as it does to process a $200.00 claim; and

WHEREAS it costs the average physician approximately $1.00 in office overhead to fill out the Blue Shield form, therefore be it

RESOLVED that in an effort to prevent the over-utilization of Blue Cross, that Blue Cross, be requested to offer to subscribers a $25.00 deductible policy; and be it further

RESOLVED that in an effort further to reduce the cost of the Blue Shield policy, Blue Shield be requested to eliminate all coverage in its plan for claims of $10.00 and under.

(If the above resolution is acted upon favorably, it is felt that the intent to help the low income group with major hospitalization and medical care can be accomplished more adequately and at a lower cost to these clients. To continue to increase the premiums such as has been the past policy will shortly, if not already, price the coverage beyond the means of the low economic group.)

"It is recommended that Resolution 61-20, New Blue Shield Contract, which dealt with a new $6,000 service contract be referred to the Committee on Advisory to Blue Shield.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-20
Blue Shield
Broward County Medical Association

WHEREAS the recent acceptance by the Federal Employees throughout the nation and in Florida of the Blue Cross-Blue Shield coverage was in the ratio of four to one in favor of the high level $6,000 service contract, and

WHEREAS at present the majority of contracts available to subscribers in the State of Florida are either $3,600 or $4,000 for a family, therefore be it

RESOLVED, That the House of Delegates request Blue Shield of Florida to develop, and if found feasible, to market, at as early a date as possible, a contract similar in scope of benefit, service level and relative value to that of the present high level Federal Employees contract, and be it further

RESOLVED, That Blue Shield of Florida be requested to cooperate with the national Blue Shield organization in the acceptance of a national professional services index or relative value in the preparation of any national account in which the Florida Blue Shield participates.

"Resolution 61-21, Recommending County Medical Society Committees on Prepayment, is approved as read at the first meeting of the House of Delegates.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 61-21
Committee on Prepayment
Broward County Medical Association

WHEREAS the latest estimate of voluntary health coverage in Florida shows that approximately 61 per cent of the people of the state have elected to participate in voluntary prepayment plans, and of this number 865,000 are subscribers to Blue Shield, and

WHEREAS there is an urgent need for strengthening the prepayment method of payment of medical care expenses to retain the personal relationship between the physician and the patient, and

WHEREAS there are numerous problems developing in the prepayment field involving the physicians and the Plans, and

WHEREAS a need has been felt to develop a closer liaison at the county level between the individual doctor and the Plan, and

WHEREAS it has been found expedient in Broward County to have a local committee on prepayment to assist in the arbitration and investigation of claims, now therefore be it

RESOLVED that the House of Delegates of the Florida Medical Association urge the development in each of the component county societies of the Florida Medical Association of a Committee on Voluntary Prepayment for the purpose of assisting in the arbitration and investigation of claims.

"We move that resolution 61-3, Social Security, be accepted as information and forwarded to our Delegates to the American Medical Association as information, since it represents the views of only one component county society; and further recommend that it not be published in The Journal.

"Mr. Speaker, I move the adoption of this portion of the report."

Dr. Beller of Dade asked why it should not be published in The Journal, since editorials by individual members on this subject have been published previously.

Dr. Edward R. Annis stated that he was away from Dade County at the time this poll was taken, that nothing went out with the poll explaining why one should be for or against it, and that while the older doctors might be able to receive more than they paid in, he thought it would be grossly unfair to the younger doctors who would never be able to draw the amount that they would be required to pay. He also stated that a time when the doctors are trying to prevent medical care for the aged being ad-

ded to the Social Security program, it would be very poor policy to approve this resolution.

Dr. Rowland E. Wood of Pinellas moved that the resolution be tabled.

Seconded by Dr. John M. Gunsolus of St. Lucie-Okeechobee-Martin.

Motion carried by voice vote.

Dr. Maxwell: "I move the adoption of the entire report as amended."

Motion carried.

The Speaker announced that the President had appointed Drs. Henry J. Babers Jr., Miles W. Thomley and William H. Keeler III, as tellers for the election of officers.

Nominations for President-Elect were called for by the Speaker.

Dr. Burn A. Dobbins Jr. of Broward nominated Dr. Robert E. Zellner of Orange.

"Five years ago, following Dr. John Milton's fine meeting at the Fontainebleau Hotel, I became fully cognizant of the leadership potential of one of our members. At that time I asked him for the privilege of one day placing his name in nomination for the office of President-Elect of the Florida Medical Association.

"I wish I had the speaking ability to hold you in anticipation and suspense until the end of my remarks, but I do not; so I will say right now I am going to talk about Bob Zellner.

"I have known Bob since 1932 when we were both freshmen at the University of Florida. This year we will not have to go north to Georgia for the birthplace of our candidate. He is a native Floridian, born in Lakeland on March 2, 1915; his parents were both born in Florida, two of his grandparents were born in Florida, and a great-grandfather was a Confederate Major in charge of the Tampa area.

"After receiving his B.S. degree from Florida in 1936, Bob decided to see how the other half lived and went north to Rush Medical School at the University of Chicago, where he received his M.D. degree in 1940. After interning at Grady Hospital in Atlanta, he spent two years as surgical resident at the Orange Memorial Hospital in Orlando.

"He married another Lakelander, the lovely Jean Brown, in 1938 and is now the father of two daughters, one of whom is a senior and the other a freshman at Emory University. Also, he has a son who is a junior in High School in Orlando.

"After serving three years as a lieutenant in the United States Navy Medical Corps attached to the Marine Amphibious Corps, in 1946 Bob settled down for the practice of surgery in Orlando. Since that time he has been active in the civic affairs of Orlando, a member and three times director of the Orlando Rotary Club, a member of the Board of Directors of the Community Chest of Orlando in 1952 and also a member of the Governor's Committee for revising the Orlando City Charter. He has headed the City of Orlando Board of Health for the past four years. He has been a member of the official board of the First Methodist Church of Orlando for the past 10 years.

"Many of you are familiar with Bob's activities in organized medicine. He served as President of the Orange County Medical Society in 1958, and has been most active in the socio-economic affairs of the Florida Medical Association. He was a member of the Health Insurance Committee in 1951-52; he was a member for four years of that great "Committee of Seventeen" which reintroduced the physicians of Florida to their forgotten offspring, Blue Shield; in his fourth year he served as Chairman of that group. He was Chairman of the Committee on Medical Economics for four years and played a large part in getting our Florida Medical Association insurance programs under way. At present, he is Chairman of the Committee on Fee Schedules.

"He has represented the Florida Medical Association on many occasions—at the Regional Conference of the American Medical Association on Prepayment Health Insurance in 1959, the Regional Conference on Blue Shield Plans in 1959, and the American Medical Association Conference on Relative Value Studies in October 1960.

"He is a member of the American College of Surgeons, the International College of Surgeons, the Southeastern Surgical Congress, and a member of the Founders' group of the Florida Association of General Surgeons. He was a member of the organizing committee of the Florida Medical Committee for Better Government and served as the second secretary of that group.

"These are times when it is most necessary that we have a President who is well versed in medical economics. In Bob Zellner, we have this man.

"For the benefit of those of you who may not know Bob personally, I just happen to have a picture of him. (First slide)

"Bob has always been a leader. When I marched in the rear ranks of the R.O.T.C., he was my corporal. That was in the days before he had developed those gray hairs along his temples. (Second slide)

"Mr. Speaker, I deem it a great privilege to place in nomination for the office of President-Elect of the Florida Medical Association, the name of Robert E. Zellner of Orange County."

The nomination was seconded by Drs. W. Dean Steward of Orange, Ralph M. Overtstreet Jr. of Palm Beach, Ralph S. Sappenfield of Dade, Ashbel C. Williams of Duval, Henry J. Babers Jr. of Alachua, Theodore J. Kaminski of Brevard, and Clyde O. Anderson of Pinellas, who moved that nominations be closed.

As there were no other nominations, the Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Zellner.

Motion carried by voice vote.

The Speaker asked Dr. Frederick H. Bowen and Dr. Frank C. Bone to escort Dr. Zellner to the platform.

Dr. Zellner: "The next best thing to an obituary is to be elected President-Elect of the Florida Medical Association. I never had so many nice things said about me before at one time in my life. When Burns was detailing the curriculum vitae Zellnerae, one of the minutia which he failed to mention was that I once belonged to Boy Scout Troop No. 6, in Lakeland. My good friend, Charlie Larsen, was also a member of the Cobra Patrol. At that time we were well indoctrinated with the motto, "Be Prepared."

"Several weeks ago I learned that a certain picture of me taken when I was about 17 years old was missing. I didn't know who had it, or for what purpose, or where I would be confronted with it, but I knew I would see it sometime.

"For the last 15 years I have been coming to these meetings and along about this time in the proceedings I have seen one of our members escorted up here, some rather wet-eyed, some shaky-kneed and some nervous, and I wondered each time what it was that affected these people this way. Gentlemen, I have learned something about them today, and I have learned something about myself, because this is, indeed, a memorable occasion. I am filled with mixed emotions—pride in being selected for this position of responsibility in the noblest of professions and the greatest of states, appreciation to you, my friends, for your confidence, and especially to my colleagues in Orange County for their wholehearted support and approval, and also humility in recognition of the problems which confront the medical profession in Florida and throughout the nation and in recognition of my own limitations.

"I fully realize, too, in spite of the nice things that have been said about me, that as a relatively junior member of this organization and, I believe, the first postwar member whom you have elected to this position, my election is certainly no reward or honor for past efforts, but is actually affording me the opportunity of being of greater service to the Association. This I accept gratefully and with the assurance to you that I will do my very best to merit your approval and to represent this Association with dignity and in a manner that will reflect credit to the medical profession. Thank you all."

The Speaker asked for nominations for the office of Vice President.

Dr. George W. Morse of Escambia nominated Dr. Egbert V. Anderson of Escambia.

Nomination was seconded by Dr. Hugh A. Carithers of Duval.

Dr. Richard S. Hodes of Hillsborough nominated Dr. Ralph S. Sappenfield of Dade.

By secret ballot, Dr. Sappenfield was elected by a majority of 81 votes to Dr. Anderson's 64.

The Vice Speaker asked for nominations for Speaker of the House.

Dr. H. Phillip Hampton nominated Dr. Joseph S. Stewart.

As there were no other nominations, Dr. W. Tracy Haverfield moved that nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Stewart.

Seconded by Dr Ralph Hertz of Monroe.

Motion carried by voice vote.

The Speaker asked for nominations for Vice Speaker of the House.

Dr. Franklin J. Evans of Dade nominated Dr. Eugene G. Peek Jr. of Marion.

Dr. C. Robert DeArmas of Volusia moved that nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Peek.

Motion carried.

The Speaker asked for nominations for Secretary-Treasurer.

Dr. Jere A. Annis of Polk for the tenth time nominated Dr. Samuel M. Day.

As there were no other nominations, Dr. Sidney Stillman of Duval moved that nominations

be closed and a unanimous ballot be cast for Dr. Day.

Seconded by Dr. Cecil M. Peek.

Motion carried.

The Speaker asked for nominations from the floor for membership on the Committee on Membership and Discipline, stating that he must have one nomination to replace Dr. Duncan T. McEwan, who had asked not to be re-elected.

Dr. W. Dean Steward nominated Dr. Thomas C. Kenaston of Brevard.

As there were no other nominations, the motion was made and seconded that the three members nominated by the Board of Governors, Drs. C. Frank Chunn for District No. 1, Dr. Frazier J. Payton for District No. 4, Dr. William C. Thomas Sr. for Distriict No. 8, and the nomination from the floor, Dr. Thomas C. Kenaston for District No. 5 be unanimously elected.

Motion carried.

The Speaker asked for nominations for Delegate to the American Medical Association to succeed Dr. Meredith Mallory whose term expires on December 31, 1961.

Dr. Edward W. Cullipher nominated Dr. Mallory to succeed himself.

Nomination was seconded by Dr. Norman F. Coulter of Orange.

Dr. James T. Cook Jr. of Jackson-Calhoun moved that nominations be closed, and the Secretary instructed to cast a unanimous ballot for Dr. Mallory.

Motion carried.

For Alternate Delegate to the American Medical Association to succeed Dr. Eugene G. Peek Jr. whose term expires on December 31, 1961, Dr. Walter W. Sackett Jr. of Dade nominated Dr. Peek to succeed himself.

Dr. Peek stated that he thought there was someone so much better qualified for the job that he would like to decline and nominate Dr. Edward R. Annis as Alternate Delegate.

Dr. Annis stated that it was a real pleasure and honor, but that in his speeches around the country, trying to reflect the viewpoint of the doctors, it might not always be an asset to be an official of the American Medical Association. He declined and renominated Dr. Peek.

It was moved and seconded that nominations be closed and the Secretary cast a unanimous ballot for Dr. Eugene G. Peek Jr.

Motion carried.

Dr. George S. Palmer of Leon nominated Dr. Burns A. Dobbins Jr. to succeed himself as Delegate to the American Medical Association for the term beginning January 1, 1962.

Dr. Walter J. Glenn Jr. of Broward seconded the nomination.

As there were no other nominations, Dr. Franklin J. Evans moved that nominations be closed and the secretary instructed to cast a unanimous ballot for Dr. Dobbins.

Motion carried.

Dr. Cecil M. Peek of Palm Beach nominated Dr. Walter E. Murphree of Alachua as Alternate Delegate to the American Medical Association to succeed himself for a term beginning January 1, 1962.

As there were no other nominations, it was moved and seconded that nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Murphree.

Motion carried.

The Speaker asked Dr. Robert G. Nelson and Dr. Charles J. Collins to escort the incoming President, Dr. S. Carnes Harvard, to the rostrum.

Dr. Wachtel: "I know I speak for this body and for the entire Association in welcoming to this office your new President, Dr. S. Carnes Harvard, and it gives me great pleasure to present to him this gavel of office."

Dr. Harvard: "Leo, it gives me great pleasure to be the one to present to you this plaque, your Certificate of Office. I am sure every time you look at it, it will bring back fond memories of the year you had more to do than at any other time in your life. You have made us an excellent President, and I want to congratulate you."

Dr. Harvard also presented to Dr. Wachtel the Past President's pin and placed it in his lapel.

The Vice Speaker escorted Mrs. Wachtel to the rostrum, and Dr. Harvard presented to her the large picture of Dr. Wachtel which had hung in the Board Room of the headquarters building during Dr. Wachtel's term of office.

Dr. Harvard: "I know the time is late and I am not going to talk very long. I regret that the first thing I have to do is something I am going to get in trouble about. I have been threatened with all sorts of dire consequences, but I would be remiss if I did not introduce to you my wife, Jimmy. She has been with me for 38 years and how she has suffered this long, I don't know.

"I regret very much that our daughter, Jane,

had a final examination at Emory tomorrow and could not be here.

"I think we have had a very successful meeting this year. The exhibitors have put on a good show, the hotel personnel has been most courteous; they have even allowed us to check out as late as six o'clock if we want. I would like publicly to thank Dr. Thad Moseley for his work on the Scientific Committee, of which he is Chairman. I understand we have had better attendance at the scientific assemblies this year than at any other time in our history. I would be out of order, too, if I did not say to Sam Day, Mr. Parham and others who run the office in Jacksonville what a nice job they have done in making this meeting a success for us all.

"I would like to follow up Dr. Askey's remarks and something George Smathers told us. Both of those talks struck a somber note. We must realize it is up to us in medicine to work as citizens, not forgetting that we are doctors, but we are driving steadily and very rapidly toward socialism. If we do not get to work and do something about it—and I know you have heard this over and over again—we are going to be socialized. First, I think we should start at the county level. Then our activities should be coordinated at the state level. Don't go off at a tangent without anyone else knowing anything about it. Let's make a united effort, and if we will do that, I think we can put the brakes on it. We have men in this organization who have talent and they should use those talents to help us all. I am sure they want to, but they can't do it unless we present a solid front."

The Speaker announced that the new Board of Governors would meet immediately following adjournment of the House of Delegates.

The meeting was adjourned at 4:20 p.m.

ABSTRACTS

Temporary Atrial Ischemia in a Case of Hiatus Hernia. By Nevzat Savranoglu, M.D., and Louis Lemberg, M.D., F.A.C.P. Am. Heart J. 58:912-915 (Dec.) 1959.

In spite of increasing interest in the recognition of the electrophysiologic disturbances of atrial musculature, there have been relatively few clinical reports demonstrating such abnormalities. These reports deal with permanent changes. Electrocardiographic evidence, however, of temporary insult to the atrial muscle, such as ischemia, has been produced by mechanical means during cardiac catheterization (demarcation or pressure potentials). A review of the literature failed to reveal a clinical case of transient atrial ischemia as a complication of other visceral involvement. The purpose of this report is to present a case of acute transient ischemia to the atrium in a patient with a large hiatus hernia. Atrial ischemia as noted on the initial electrocardiogram occurred at the time of severe upper abdominal distress and disappeared in subsequent tracings taken 17 and 45 hours later. This condition was believed to be produced by acute pressure of the stomach on the posterior wall of the heart following paraesophageal hiatal herniation.

Postprandial Hypoglycemia Presenting as a Neurologic Problem. By Warren L. Belding, M.D., and David A. Freedman, M.D. Neurology 10:613-618 (June) 1960.

It is well known that a wide variety of neurologic and psychologic abnormalities may occur as a result of hypoglycemia. Particularly in the early phases of this metabolic disturbance, its manifestations may readily be confused with those of psychoneurosis. Such a confusion in diagnosis is one of the features of the case here presented. The authors believe, however, that this instance of a not uncommon phenomenon is of interest not simply because of the difficult differential diagnosis but also because of the etiology of the hypoglycemia. While the occurrence of low blood sugar in the delayed phase of the dumping syndrome has frequently been reported, they were able to find only one case reported in the literature in which so severe a neurologic reaction as they report was present. In addition, their patient gave evidence to support Berry's suggestion that a tendency to hypoglycemia may precede, if not even be of etiologic significance in, the development of peptic ulcer. From both the neurologic and the psychiatric standpoints, this patient presented features that seemed to them equally as provocative as his gastrointestinal problem. The particular problems with which they had to deal in this case were, first, the occurrence of focal changes on both neurologic examination and electroencephalographic study during prolonged periods of lowered blood sugar and, secondly, the striking behavioral characteristics of the patient during normoglycemic as well as hypoglycemic periods.

Thoracoabdominal Injuries. By Harold O. Hallstrand, M.D., F.A.C.S., F.I.C.S., D.A.B. J. Internat. Coll. Surgeons 33:751-756 (June) 1960.

In contrast to the management of wartime thoracoabdominal injuries, in civilian life failure to recognize and to treat thoracoabdominal emergencies adequately remains one of the main causes of traumatic death. Thoracic injury interfering with respiration always commands first priority, and its repair takes precedence over abdominal problems. In cases of fractured ribs or other severe thoracic injury, possible injury to the liver or the spleen must be kept in mind. A lacerated spleen should always be removed. An abdominal trauma may be obscured by extensive concomitant thoracic injuries. After thoracoabdominal trauma a "silent abdomen" means peritonitis, and operation is mandatory. Signs of perforation of a hollow viscus may be delayed by shock, intestinal spasm or plugging of a laceration by omentum or adhesions. It is fundamentally important, however, that the tracheobronchial tree be kept unobstructed and that secretions be removed bronchoscopically and by tracheostomy when coughing is ineffectual.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

President's Page

In Unity, Strength

I wish at this time to express to you again my sincere appreciation for the honor you have bestowed upon me by electing me your President.

This is the beginning of a new year. There are many changes within your organization, but basically these are personnel changes. There are no New Deals or New Frontiers, but we have plenty left over to work on, and new problems are constantly coming up.

Most of us recently attended the Annual Meeting of the Florida Medical Association in Miami Beach. Since that meeting I am sure that we all are more aware of the problems that are facing us than ever before. How are we going to solve these various issues?

In the first place, we must realize that the solution must come from us. We cannot expect somebody else to do this for us and neither do we want them to. We cannot accomplish this unless there is complete accord within our own organization. There is always a difference of opinion when even two individuals get together, to say nothing of a group our size. This harmony can best be arrived at by a complete airing of opinion on all problems. There, of necessity, has to be give and take on both sides with the realization that the solution we arrive at has to be the best one not only for us and our patients but also for future doctors and their patients as well. Doctors are individuals and all of us are accustomed to making decisions. We have learned through experience that these decisions must be right.

If we will make a concentrated effort to clean up our own house, then I feel that we can face external issues with greater effectiveness. The old saying that there is strength in unity certainly holds good here. This will all entail a great deal of thought and work on the part of every one of us. We cannot leave this up to just a few. It must start at your county level and end in the Florida Medical Association headquarters. I am a firm believer in home rule here as well as in our government. Your officers and Board of Governors want to do what they can, but the ultimate decision must come from you. Be tolerant, act wisely, but above everything else, work. Many of you have been put on committees both local and statewide. This I hope you will consider a privilege as well as a duty. Learn what your duties are and carry them out. Do not be apathetic, or develop a defeatist attitude. If you do your job as a doctor well, develop your public relations beyond reproach, do not neglect your responsibilities as a citizen and really try, there is nothing to fear.



EDITORIALS

Editor Emeritus Awarded Certificate of Merit

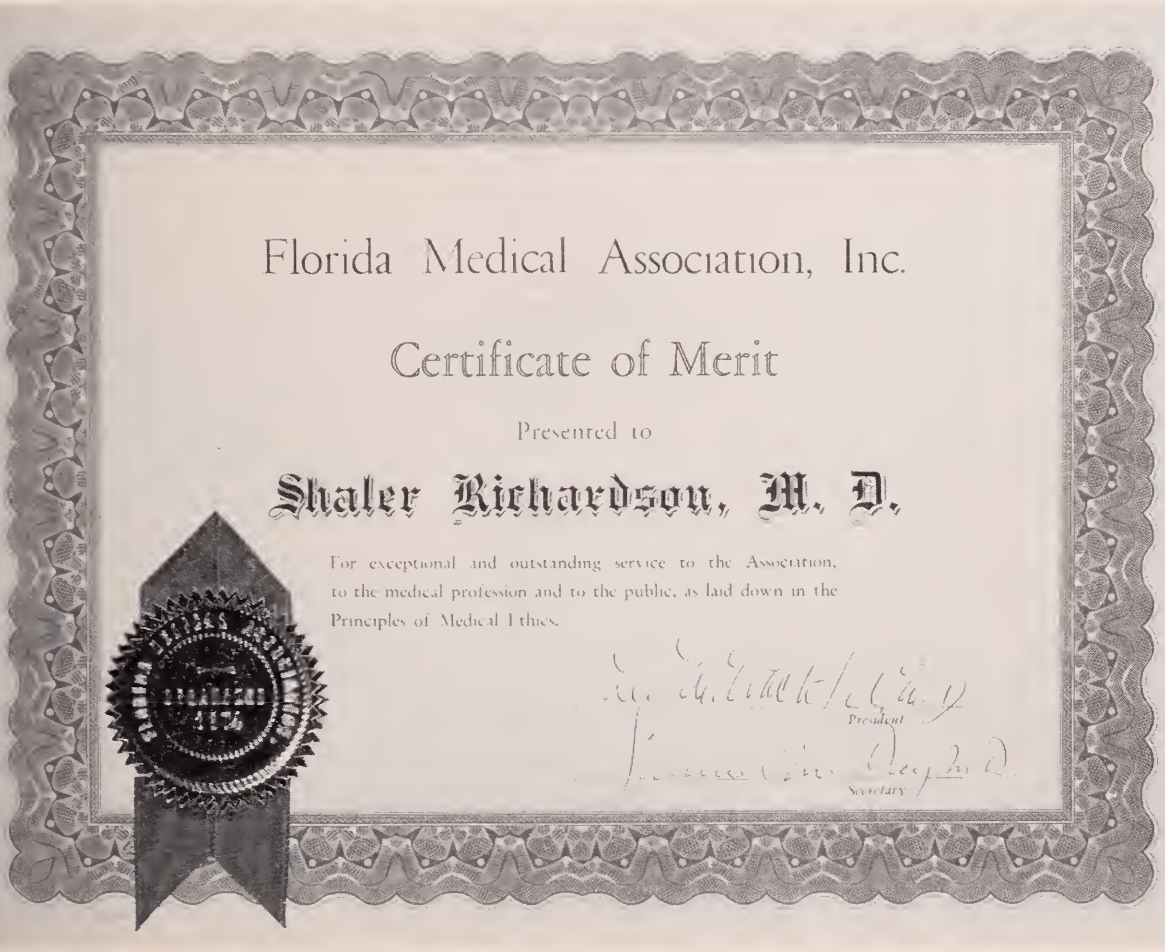
Upon May 28, 1961, Dr. Shaler Richardson became Editor Emeritus of The Journal of the Florida Medical Association. With this change in status for one who served as its Editor for 33 years, during which the growth of the Association and The Journal has been explosive, your Journal loses a faithful guiding hand. Throughout these years The Journal has been aware of its obligation to serve as a sounding board for the scientific and socioeconomic thinking of the Florida Medical Association membership and has developed steadily to serve this purpose. Yet these changes have been accomplished so quietly that we members of the Association were hardly aware of them.

This is the mark of a wise and far-seeing guiding hand—that of the Editor for more than three decades.

As Editor pro tem of The Journal, I look forward to a close association with Dr. Richardson,



Dr. Richardson receives the Certificate of Merit from Dr. Leo M. Wachtel, President of the Association.



Florida Medical Association, Inc.

Certificate of Merit

Presented to

Shaler Richardson, M. D.

For exceptional and outstanding service to the Association, to the medical profession and to the public, as laid down in the Principles of Medical Ethics.

President

Secretary

for his knowledge and experience are needed in the continuing effort to keep The Journal at the present level of excellence it has reached under his guidance.

THAD MOSELEY, M.D.
EDITOR PRO TEM

At the recent Annual Meeting of the Florida Medical Associtaion, Dr. Richardson received the Certificate of Merit, the Association's highest honor. He is the second recipient of this award. The resolution presented by the Board of Governors nominating him for this honor follows:

WHEREAS, Shaler Richardson, M.D., of Jacksonville, a distinguished life member of the Florida Medical Association, has rendered outstanding service to the medical profession, to the public, and especially to the Association throughout the thirty-nine years of his membership, and is therefore worthy of the Association's highest tribute;

WHEREAS, This eminent physician, born in Lake Charles, Louisiana, on February 27, 1891, was the son of a prominent physician there and the nephew of a well known Florida physician, was awarded the degree of Doctor of Medicine by Vanderbilt University School of Medicine in 1913, served a two year internship at the Memphis City Hospital, then served his country in World War I for two years as a major in the Medical Corps of the United States Army, and thereafter was a resident for four years at the New York Eye and Ear Infirmary;

WHEREAS, In 1922, this noted doctor entered the private practice of medicine in Jacksonville, was elected Secretary-Treasurer of the Florida Medical Association and Editor of The Journal of the Florida Medical Association in 1925, served in this dual capacity for nineteen years, held numerous regular and special committee assignments through the years, became President-Elect in 1944 and held that office for two war years, served as President in 1946, resumed the post of Editor of The Journal in 1947 and continued to serve in that official capacity until the present time;

WHEREAS, This faithful servant of Medicine has filled important posts throughout his career in the organizations of his specialty and has long been a leading figure in every type of work for the blind, was a charter member and is a past president of the Florida Society of Ophthalmology and Otolaryngology, is a former member and a past president of the Florida State Board of Health, is a past president of the Duval County Medical Society, has filled with distinction the highest staff positions of the hospitals of his community, and has received wide recognition in local, county, state and national medical organizations for his loyal service and unflagging zeal;

WHEREAS, This distinguished physician became the second Editor of The Journal only eleven years after its founding, has during his thirty-three years at its helm guided this organ of the Association to a place of prominence among state medical journals which reflects great credit on his leadership, and today assumes the post of Editor Emeritus by appointment of the Board of Governors; Therefore, be it

RESOLVED, That the Certificate of Merit, the Association's highest honor, be awarded to this untiring devotee of the healing art, exemplary member and faithful officer of the Association, dedicated Editor of The Journal, and devoted servant of the public, in recognition of his unselfish service, prodigal expenditure of time and talents, personal sacrifices, and countless contributions to The Journal, to the progress of the Association, to the betterment of organized medicine and to the welfare of the public.

Land of the Free

One hundred and thirty-five years ago—on the fourth of this month, and on the fiftieth anniversary of our Independence—two Titans of American history died within a few hours of each other. Only in death did John Adams and Thomas Jefferson end their lifelong, dedicated and unselfish service to the cause of freedom, in general—and to the young Nation which they so dearly loved, in particular. Both of them had willingly sacrified their entire adult life for the cause which they so deeply espoused. They did this gladly, willingly and thoughtfully, for the freedom which they championed was not the wild-eyed, irresponsible, selfish prerogative of the exercise of free will as it opposed the aims and the interest of society, but rather the restrained, moderated and lawfully controlled exercise of those basic rights and responsibilities which should be equal in every man—freedom which would improve democracy and government, not destroy it—the controlled

freedom of ardent, vigorous but wise men, visionary, and not the least self-centered or self-motivated.

These men were well aware of the deficiencies and dangers of a democracy—pitfalls that later led Winston Churchill to remark that a democracy is the worst form of government, except all others. They were aware that it could not guarantee its own survival, since the human pieces that it dealt with were far from perfect; yet they knew it was the best available form of government and that its security and its safeguard lay in the education of its constituents and in their ability to reason from their knowledge. For a democracy is not the rule of the majority, or even of the people; a democracy is *each single individual* who makes it up—the small voice that is heard—the tiny will that is felt—the importance and the dignity of each of us. And each of us must be informed, understanding and rational, if we are to preserve this government. Its preservation demands not only our courage and our convictions, but our education and our reason. If we are to remain the "land of the free" that Thomas Jefferson and John Adams envisioned and laboriously launched, we must each devote vigorous effort toward the education and instruction of the entire citizenry in those basic and logical concepts of freedom, responsibility and self sufficiency that led to the founding of the country—to the realization, in short, of the fact that we, individually, *are* the Government, that we support, maintain and control it—not allow it to support us.

This education and evidence of faith we owe to our fathers—and to our children.

Jere W. Annis, M.D.
Lakeland

Epitaph of an Humanitarian

"When a great man dies, the immortals await him at the top of the nearest hill."—George Meredith.

Rarely in our career on this earth, regardless of the type of endeavor, do we have the pleasure of knowing a truly great man. Such a man, many believe, was Louis M. Orr. He possessed the qualities and characteristics which are exemplified in the Hippocratic oath in the truest sense. He lived by its tenets and practiced his profession in a spirit of dedication matched by few. Never lacking in determination, those who knew him could sense the radiation of zeal and purposeful action which was his trademark. A perfectionist and an enthusiast in all his endeavors, he had many interests. A born leader in his profession, he was also one of the country's outstanding urologists. He possessed an amazing storehouse of knowledge on many subjects and was an avid sportsman. He was an expert hunter, fisherman, golfer, photographer and gardener. He loved children, and as a result the Orr yard was an Orlando playground for many youngsters over the years. He organized the football and supervised the boating activities with enthusiastic pleasure.

Dr. Orr had deep convictions on the principles of good government and the free enterprise system. He was a vigorous defender of conservative practices and abhorred the trend to federalization of our entire economy. He had been active in organized medicine for 20 years and in that time undoubtedly contributed more to the needs of his profession than any other physician in the South. Medical leadership is frequently ineffective because of the lack of training for it and the necessity of maintaining a medical practice while in office. Louis Orr, however, was one of the strongest spokesmen for medicine in American Medical Association history and probably made more public appearances than any of his predecessors. He was a dynamic and forthright speaker who strove to depart from stereotyped vagaries and instead drove home the real issues at hand with forcefulness and, at times, eloquence. His personal charm and appeal, however, were perhaps his greatest attributes and these will be the qualities long remembered by us all.

The real tragedy lies in the fact that the demands upon our medical leaders, particularly on a national scale, are so great that their lives are frequently sacrified. American medicine has reached its most critical period in history and now is in dire danger of being engulfed by its own

government. There was a time when a Physician had confidence in the future, with a solid reassurance that he could concentrate his entire energies alleviating the ills of his fellow men. But there has developed a philosophy of federal "cooperation" which aims to improve this service—to shackle us by regimentation and standardization. Our only defense has been the development of a strong voice in our American Medical Association leaders that can reach the people to plead the cause of free medical care. This, unfortunately, has become a 24 hour a day job which is not only grueling and exhausting, but demands the patience of Job and the diplomacy of a consul. The wording of every public statement must be well chosen to insure that a hostile press may not alter it in such a way as to react against us. Socializers on every hand are seeking to impugn the very motives of our leaders, even to attacking them on moral issues. Alas, a few of them are in our profession. Little wonder that our profession has difficulty in securing top flight talent to represent us when the price to pay is so great.

Many of us may still have unfulfilled our debt to society, but Louis M. Orr's obligation has been repaid a thousand fold. We are indeed grateful to him, but only regret that he could not live to reap the fruits of his efforts. May he in death then be accorded the final reward which he so richly deserves.

MILES W. THOMLEY, M.D.
ORLANDO

MEDICAL NEWS

A Portrait of Medicine

Panorama of the Eighty-Seventh Annual Meeting of the Florida Medical Association

This anecdote really begins four score and seven years ago when 10 founder members met in the home of Dr. A. S. Baldwin in Jacksonville to organize the Florida Medical Association and elect their host its first president. The meeting evolved around an ecstatic spirit of predicting the future of medical practice in Florida. At the outset the ancestral organizers recognized the value of medical conventions as a vital means of educational communication providing a source of original information beneficial to the profession.

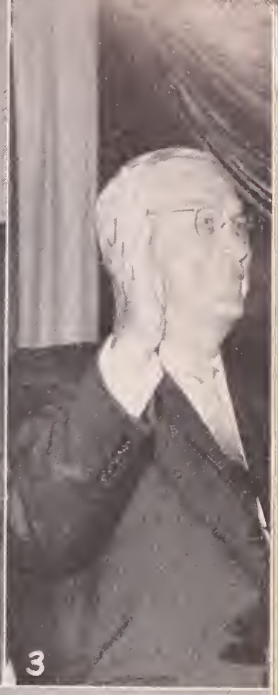
If these 10 pioneer medical vanguards of our state organization could have attended the Eighty-Seventh Annual Meeting at Bal Harbour, Miami Beach, on May 25-28, 1961, they would have been justly proud and exceedingly gratified with the fruits of achievement their seeds did bear. The convention headquarters, most gloriously and exaltedly named The Americana, was in format a "Reader's Digest" of medical information. The second largest group of registrants in the Association's convention history was welcomed in the foyer by an array of hobby talents befitting only those of eminent artistic prowess—our own colleagues. To register officially (and this task was expedited by Mr. Harold Parham's adept staff) it was necessary to approach the registration desks by traversing one of many rows of scientific

Opposite Page

Highlights of the Eighty-Seventh Annual Meeting in Bal Harbour, Miami Beach: 1. Presentation by Dr. Wachtel to Dr. Edward R. Annis of Miami of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." 2. Dr. Wachtel presents a personal gavel to Dr. Joseph S. Stewart of Miami, Speaker of the House. 3. Dr. E. Vincent Askey, President of the American Medical Association, acknowledges the applause of the House of Delegates. 4. Dr. Wachtel delivers his Presidential Address. 5. Dr. S. Carnes Harvard of Brooksville is escorted to the platform by Dr. Chas. J. Collins of Orlando (right) and Dr. Robert G. Nelson of Tampa. 6. A personal gavel is presented to Dr. Harvard by Dr. Wachtel. 7. Dr. Robert E. Zellner of Orlando, chosen President-Elect, is escorted to the platform by Dr. Frederick H. Bowen of Jacksonville (left) and Dr. Frank C. Bone of Orlando. 8. The officers of the Association (from left): Dr. Eugene G. Peek Jr. of Ocala, Vice Speaker of the House; Dr. Joseph S. Stewart of Miami, Speaker; Dr. Zellner; Dr. Harvard, and Dr. Ralph S. Sappenfield of Miami, Vice President.

















and technical exhibits. The caliber of the scientific displays has been unequaled in regard to intellectual quality and practical significance by previous meetings. The commercial booths were a pageant of variety and they were managed by representatives who prided themselves on discussing their products to the fullest extent with interested conventioners. The telephone service was an appropriately conducted asset for the membership's convenience.

The Scientific Assemblies formulated by Dr. Thad Moseley were an unrivaled contribution to this meeting, blanketing a variety of topics from atoms to antibiotics, yet imbricating the specialties in such manner that the medical eye was not restricted nor confined to any certain field without realizing the dependency on other fields in achieving success. It takes words to make a page, pages to make a book and books to make a library. A library of knowledge could be in the making if all the papers presented at the Scientific Assemblies would be combined with those delivered at the meetings of the specialty societies.

The General Session was called to order by President Leo M. Wachtel, who in his usual adroit manner introduced the guest speaker, the Honorable George Smathers, Florida's junior United States Senator. The Senator's address was most informative and well received by the combined audience of members and their wives. He concluded his timely presentation by implying that Fidel Castro of Cuba needed less of our hand shaking and more of our fist shaking.

As it should be, a medical convention must exercise some order of business and this was accomplished by two meetings of the House of Delegates. For the first time in the history of the Florida Medical Association, the House of Delegates was presided over by a Speaker and a Vice Speaker. Dr. Joseph S. Stewart proved to be a superb tactician and with this God-given talent he conducted the multitude of difficult problems that the delegation presented like a Pied Piper down the road to finality. The Speaker was relieved at intervals by the Vice Speaker, the amiable soft-spoken Dr. Eugene G. Peek Jr., who leisurely and inexcitably filled his boot of duties with a credibly covered foot that appealed to the contented delegates. This new and untried manner of conducting business at the Annual Meeting certainly met with approval and it appears to be a continuation because both of the Speakers were re-elected unanimously for another term of office.

Among the many distinguished persons in the audience were Minister Ralph B. Huston, First Methodist Church, South Miami, who presented the invocation; Dr. Willard L. Fitzgerald, President of the Dade County Medical Association, who welcomed the delegates; President-Elect, Dr. S. Carnes Harvard; Vice President, Dr. Clyde O. Anderson; Secretary-Treasurer, Dr. Samuel M. Day; Immediate Past President, Dr. Ralph W. Jack; Executive Director, Mr. W. Harold Parham; President of the Woman's Auxiliary, Mrs. John M. Butcher, and President-Elect of the Woman's Auxiliary, Mrs. W. Dean Steward. Dr. James T. Cook Jr., who is the American Medical Association General Practitioner of the Year Award winner, was introduced.

The highlights of the first meeting of the House of Delegates were speeches by Dr. E. Vincent Askey, President of the American Medical Association, and President Wachtel. Dr. Edward R. Annis was honored with the A. H. Robins Company award "For Outstanding Community Service by a Physician." The Certificate of Merit, the Association's highest award, was presented to Dr. Shaler Richardson. At the second meeting of the House of Delegates election of officers took place, and Dr. Robert E. Zellner was made President-Elect. Dr. Ralph S. Sappenfield was elected Vice President, and re-elected, in addition to Dr. Stewart and Dr. Peek, was Dr. Samuel M. Day, Secretary-Treasurer. The incoming President, Dr. Harvard, was then inducted into office. Following the benediction by Dr. Homer L. Pearson Jr., the meeting was adjourned. The attendance record was physicians 1,081, lay guests 123, Woman's Auxiliary 353, technical exhibitors 294 and scientific exhibitors 48. The total registration was 1,899.

One notable face was absent from the convention. This physician occupied a position in American medicine unparalleled in honor and respect, and the reason that he was not present was without question that he drove himself beyond the point of human endurance so that public health maintained public wealth. Today he stands with our 10 founder members looking upon us and guiding our styles of behavior, our standards of ethics and our goals of aspiration. We will always cherish the leadership of our devoted deceased Dr. Louis M. Orr.

The doctors who temporarily laid aside their stethoscopes and scalpels to attend this Eighty-Seventh Annual Meeting have now returned to their homes to resume their practices. There is

little question that they benefited greatly from this week end of rest, learning and enjoyment with their colleagues. To you who were unable to attend, make plans to be present at the next meeting.

Clifford C. Snyder, M.D.
Miami

Scientific Exhibit Awards

A committee from the Board of Past Presidents of the Florida Medical Association, serving as judges, selected as award winners 13 exhibits out of the 37 assembled for the Scientific Exhibit of the Eighty-Seventh Annual Meeting of the Association, held May 25-28 at Bal Harbour, Miami Beach.

The first place award ribbon was given to the exhibit entitled "Regional Perfusion in Man," presented by Dr. Daniel S. Martin of Miami, Associate Professor of Surgery and Director of Surgical Research Laboratories at the University of Miami School of Medicine. The second place ribbon went to the exhibit entitled "Pathogenesis of Synovial Osteochondromatosis," presented by Dr. William F. Enneking of the University of Florida College of Medicine in Gainesville, and the third award ribbon to the exhibit "Lymphography," presented by Drs. Raymond E. Parks and Manuel Viamonte of Jackson Memorial Hospital and the University of Miami School of Medicine in Miami.

The committee selected 10 exhibits for merit award ribbons. These included "Experimental and Clinical Use of Fibrinolysin," Drs. Paul W. Boyles, William H. Meyer and Paul U. Gerber Jr., Coagulation Research Department, Miami Heart Institute and the University of Miami School of Medicine, Miami; "Acceptable Operations on the Biliary Tract," Drs. Harry W. Reinstine Jr. and Emmet F. Ferguson Jr., Jacksonville; "Snake Bite and Treatment," Dr. Newton C. McCollough, Orlando; "Cervical Cytology—A Gynecologic Challenge," Dr. J. Allan Offen, Miami; "Microwave Studies," Wm. B. Deichmann, Ph.D., University of Miami School of Medicine, Coral Gables; "Automotive Crash Injury Research," Mr. Robert A. Wolf, Director, Automotive Crash Injury Research of Cornell University, New York City; Woman's Auxiliary to the Florida Medical Association, Mrs. John M. Butcher of Sarasota, President; "Reconstruction After Head and Neck Surgery," Dr. John J. Fomon, University of Miami School of Medicine and Jackson Memorial Hospital, Miami; "A Comparative Review of the Methods of Practicing Medicine—'Then and Now'," Committee on Archives, Florida Medical Association, Dr. Clifford C. Snyder, Miami, Chairman; and "Delayed Postoperative Anorectal Hemorrhage: Newer Developments and Techniques in Its Control," Dr. Frederick E. Farrer, Miami.

Hobby Show

The Second Annual Hobby Show of the Florida Medical Association was held at the Americana Hotel, Miami Beach, May 25-28, 1961, as a part of the Eighty-Seventh Annual Meeting of the Association. In the Arts and Crafts Division, there were 38 entries from 12 physicians, six of whom won merit awards:

Dr. Wilfred Lansman of Miami Beach for a driftwood and ceramic sculpture entitled "Seahorse;" Dr. Jacob A. Glassman of Miami Beach for a plaster of Paris sculpture with metallic patina entitled "Prehistoric Man and Fire;" Dr. Philip Weinstein of Miami for a tile mosaic entitled "Blue Clown;" Dr. Martin P. Mahrer of Miami for a plaster of Paris sculpture entitled "Portrait of a Girl;" Dr. Philip M. Greenberg of Miami Beach for an oil painting entitled "Abstract No. 18;" and Dr. Joseph W. Ketzky of Miami Beach for an oil painting entitled "Indonesian Girl."

In the Collections and Displays Division there were three entries with two merit awards presented to:

Dr. Ralph S. Sappenfield of Miami for his collection of antique iron toys, and Dr. Charles K. Donegan of St. Petersburg for his collection of antique maps of Florida.

Wilfred Lansman, M.D.

Golf Tournament

The annual Florida Medical Association Golf Tournament was held at the North Dade Country Club during the Annual Meeting of the Association. Dr. Robert C. Piper of Coral Gables was chairman of the Golf Committee. The co-chairmen were Drs. Truxton L. Jackson and Francis N. Cooke of Miami. A total of 28 physicians participated with 10 winning awards. Dr. Henry H. Bryant III of Coral Gables won the Orlando

Loving Cup presented by the Orange County Medical Society with a low gross score of 73. Dr. Donald McMahon Jr. of Pensacola won the Duval County Medical Society trophy with a low net score of 72. Second low gross score was 75, turned in by Dr. Truxton L. Jackson of Coral Gables; third low gross score was 83, turned in by Dr. Roy W. Brown of Belle Glade; and fourth low gross score was 84, turned in by Dr. Arthur W. Wood Jr. of Miami.

The other low net winners were Dr. Edson J. Andrews of Tallahassee, who was second low net scorer with a 73 (79-6). Third low net scorer was Dr. Herbert B. Lott of Tampa with a 73½ (83-9½). Fourth low net score was turned in by Dr. Clarence L. Anderson of Lakeland with a 74 (87-13), and fifth low net score was 75 (86-11), turned in by Dr. Nathan Weil Jr. of Jacksonville.

WILFRED LANSMAN, M.D.

State Science Fair Winner Given National Award



The top American Medical Association award for the best exhibit in the basic medical sciences at the 12th National Science Fair-International in Kansas City, Mo., May 10-13, was presented to Christopher G. Cherniak of Eau Gallie, a senior at Melbourne High School. Young Cherniak previously had won the Florida Medical Association's top awards in both 1960 and 1961 at the Florida State Science Fair. Hosts at the Health Awards Banquet in Kansas City were the American Medical Association, American Dental Association, American Pharmaceutical Association, and the American Veterinary Medical Association. All four presidents attended, and Dr. E. Vincent Askey of Los Angeles (right), president of the American Medical Association, awarded young Cherniak's citation and invited him to exhibit his presentation at the Association's 110th annual meeting in New York City on June 25-30.

CLINICAL COMMENT

Under this heading, The Journal presents information gathered by members of the Florida Medical Association at the various medical meetings. The thoughts expressed are those reported by the author and are not intended as scientific references.

Scientific Highlights American College of Physicians Meeting

The Forty-Second Annual Session of the American College of Physicians was held May 8-12, 1961, at Miami Beach. Approximately 150 lectures, panels, clinicopathologic conferences, and clinics were presented by a total of 430 authors and speakers, making it impossible to attend each event on the program and difficult to choose the most important papers. Total registration was 4,950 persons.

Bacterial infections were discussed by many authors. Enterococcal endocarditis was reported to have the genitourinary tract as the commonest portal of entry, and to have affected five patients without apparent heart disease out of a group of 19 cases. Despite the in vitro resistance of the enterococcus to penicillin or streptomycin, the combination of these drugs gave good in vivo results, with 84 per cent of the patients being cured. In another group of 167 patients with subacute bacterial endocarditis due to a variety of microorganisms, 37 (22 per cent) had no underlying heart disease. The mortality rate dropped from over 80 per cent prior to penicillin therapy, to 38 per cent in the last five years. Hydrodynamic factors were studied experimentally, and may explain the failure rate, since they showed that subacute bacterial endocarditis occurs only at sites where high pressure gradients extrude blood at high velocities through narrow orifices, reducing lateral pressure locally and thereby eliminating normal perfusion from lumen to intima and preventing expected perfusion of antibiotics through the site, even if present in high concentration in the immediately adjacent arterial blood.

Candida endocarditis was described as an emerging peril in cardiovascular surgery. It was reported in six patients, five of whom had had prior cardiac surgery and all of whom died. Because 14 of the patients in the 21 known cases of endocarditis due to superinfection with Candida had had prior antibacterial therapy, experimental infections were induced in dogs following

surgical production of aortic insufficiency, and the disturbing fact emerged that prior antibacterial therapy was *essential* to the production of experimental Candida endocarditis.

An exciting new derivative of synthetic penicillin, potassium *a*-phenoxyethyl penicillin (Penicillin L), was reported to have activity against staphylococci and resistance to penicillinase; more important, if small amounts of Penicillin L are added to penicillin G, it protects penicillin G from deactivation by the penicillinase present intracellularly in staphylococci.

Bacteriuria received attention from several speakers, who concluded that it is present in 0.5 per cent of normal men, 2.2 to 6.6 per cent of normal women, and 4 to 7 per cent of pregnant women, and that the incidence is higher in patients with diabetes and in women with cystoceles, and reaches 98 per cent in patients who have had an indwelling catheter for four days or more. The vigorous treatment of asymptomatic bacteriuria was advocated, since by so doing the incidence of acute pyelonephritis of pregnancy was reduced from 19 per cent to 0 per cent in untreated controls, and in postpartum women from 14 per cent to 8 per cent (the latter perhaps due to catheterization at the time of delivery.) Prematurity was reduced from 27 per cent to 7 per cent in the treated group, and neonatal deaths from 14 per cent to 0 per cent. In addition, after the age of 30 the presence of bacteriuria was associated with a significant increase in hypertension, and it was postulated that at least some cases of hypertension might be prevented by eradication of asymptomatic bacteriuria prior to the onset of hypertension.

The Lilly Lecture, entitled "Essential Hypertension: Incidence, Course, and Heredity," was presented by Sir Robert Platt, M.D., Professor of Medicine, University of Manchester, and President of the Royal College of Physicians. His thesis was that essential hypertension can be made as a positive diagnosis (not by excluding other causes of hypertension) and that there is a strong family history with definite genetic factors present, the siblings being either normotensive or definitely hypertensive. Essential hypertension rarely appears before age 40, appears to be similar to pyelonephritic hypertension, is rarely seen following toxemia of pregnancy, and appears unrelated to nervous tension or environment. He urged continued studies of the families of hypertensive patients.

Several papers concerned cellular chemistry, with particular reference to desoxyribonucleic acid (DNA) in its relation to immunity. The diseases of connective tissue (collagen diseases) were explored as perhaps being due to an autoimmune response to constituents of the cellular nucleus or cytoplasm, and observations made of the association of more than one autoimmune disease in the same patient, and the detection of serological abnormalities and related diseases in first degree relatives of patients with certain of the connective tissue diseases.

John M. Packard, M.D.
Pensacola

Miami Beach Meeting American Society of Internal Medicine

The Fifth Annual Meeting of the American Society of Internal Medicine was held on May 6-7, 1961 in Miami Beach, just before the national convention of the American College of Physicians. This year's slogan was "Internal Medicine and Society Today."

Mr. James Brindle, Director of the Social Security Department of the United Automobile Workers of America, presented an address entitled, "Labor's Concern with Medical Care." Leonard W. Larson, M.D., President-Elect of the American Medical Association, described the goals of organized medicine. His subject was "Ten Out of Every Ten Doctors."

Walter J. McNerney, Professor of Hospital Management at the University of Michigan, presented two papers, one, "The Social and Economic Responsibility of the Physician," and the second, "The Maintenance of Standards of Medical Practice." Not only did he insist that it is possible to measure good medical care in the hospital as well as out, but he emphasized that the physician must become involved in the economic and social structure of the patient and that this is not only the responsibility but the opportunity of the doctor if he wishes to avoid what he terms socialized medicine. He illustrated that this has come about because of social pressure related to movement of the population, increased activities of labor, the organization of this country into metropolitan areas, and the development of government influence at all levels.

"The Government's Role in Health Affairs" was the subject presented by Mr. Kenneth Williamson, Director of the American Hospital

Association. Mr. Andrew E. Ruddock, Director of the Bureau of Retirement and Insurance of the United States Civil Service Commission, discussed all the details and problems and answered questions concerning "Federal Employees Health Benefits Act of 1959," under which physicians are already involved in the medical care of some 15,000,000 federal employees. A paper entitled "The Internist and Group Practice," presented by S. David Pomrinse, M.D., Chief, Health Professions Branch, Division of Public Health Methods, was an exhaustive survey of the trends all over the United States in the direction of different types of group practice and complete medical care plans through groups. Mr. Boisfeuillet Jones, Special Assistant to the Secretary of Health, Education, and Welfare for Health and Medical Affairs, who is a colleague of Professor Wilbur J. Cohen, the author and chairman of President Kennedy's task force of all of the health proposals under Secretary A. A. Ribicoff, presented a paper entitled, "The Administration's Proposals for Health Care."

The highlight of the entire convention, however, was two panel discussions participated in by all of these speakers and, in addition, Jere W. Annis, M.D., and Charles K. Donegan, M.D., of Florida; George K. Wever, M.D., President-Elect of the American Society of Internal Medicine, who was one of the authors of the San Joaquin County, California Group Plan, and Lewis T. Bullock, M.D., Past President, of California; H. J. Lehnhoff Jr., M.D., of Nebraska, and L. Philip Longley, M.D., of Ohio, both members of the Board of Trustees. These panel discussions were so informative that they were presented on two days under the general titles of: "Can We Improve Medical Care and Reduce the Cost?" and "Is the Quality of Medical Care Improved When the Patient Directly Participates in Its Payment?" These clearly illustrated the two viewpoints of Social Security payment versus health insurance methods by all participating, and all in the audience not only gained information but appreciation of the cooperation of representatives of the different extremes discussing the problems with understanding and respect.

The convention was addressed at luncheon by Chester S. Keefer, M.D., President of the American College of Physicians, and it was thought by all concerned that the American Society of Internal Medicine was encouraging mutual understanding with representatives of government, labor and hospital administration at a level never before approached.

LAWRENCE E. GEESLIN, M.D.
JACKSONVILLE

Correction

The editorial "Self-Policing of Blood Banks" published on page 1365 of the June issue was written by Dr. John B. Ross of Jacksonville and his name should have appeared as author.

OTHERS ARE SAYING

Disorganized Medicine

In 1415, at Agincourt, France, the hungry, disease-ridden, battle-weary remnants of Henry V's army were trapped while attempting escape back to England.

Faced by the finest warriors of France, outnumbered 5 to 1, the English had little hope for their future. The choices seemed to be either surrender or be slaughtered. Shakespearian fans remember his portrayal of demoralized men urging surrender but wishing escape; and the braver souls, asking only intelligent leadership. Unfortunately for the faint-hearted, there was no escape —only surrender and submit, or fight, with the issue very much in doubt. This situation seems a remarkably close parallel to the condition of American Medicine today.

The doctors, of America, are faced with a well-organized enemy which will allow no escape and the intent to force a pitched battle at the earliest opportunity. Our surrender to the "New Frontier" would be eagerly accepted. On the other hand, the odds in our favor seem equal to those of the English before Agincourt.

What are the attitudes and morale of our army? The attentive listener to coffee conversation can't help but wonder if we really deserve to be called 'organized medicine.' There are those who cheer the hollow victories, such as the Dr. Annis—Walter Reuther debate, and relax and think everything will be all right. Others say "it" is coming no matter what we do, so why waste our energy! A small but vociferous group stoutly announces its great sacrifice for charity, refusing to believe that medical services, in any sphere, can be honestly criticized, or could be improved.

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The only constructive suggestion this hardy band of cynics has is that we broadcast their numerous humanitarian virtues to the public. If the right hand knows what the left hand is doing, we have lost the avowed spirit of charity which should always separate medicine from other professions and callings. On the battlefield medals are given only for service above and beyond the call of duty.

I hopefully believe that a majority of doctors have "turned the light within." They ask themselves, and each other, what they can and should now do to raise American Medicine above reasonable criticism; and to meet head-on the threats of self-seeking agitators who pervert the public trust by manufacturing intellectual garbage to be thrown at American doctors.

Up to now our battle has been fought on national levels by the A. M. A. Always we were seen as opponents of medical reform bills. The fight now must shift to the county level, and we must play offense as well as defense. Bad medical legislation must be crushed; but, good legislation deserves our support. Laymen, and recently, some doctors, observe that the doctors as a group are always *against* everything but never for anything except the status quo. In the past, this had to be so because no layman could know, completely, what is good for both the patient and doctor. As a guiding principle we all admit that what is good for the patient is good for the doctor.

The sad truth was that we were usually too disorganized to agree on reasonable needs in our respective communities, too busy to fight legislative battles as a group; and, at times, so distrustful of our own judgment that we were paralyzed into inactivity.

Considering our situation in Washington, it must be obvious that our success can come, only, on the county level. The faded crimson of Harvard has not quite paralyzed our sovereignty in Duval County. We have only to organize; study our problems here; formulate solutions reasonable to us and our patients; and then, fight for what we believe.

How long will we, as individual members, remain passive and disinterested on such issues as: 1. the County Hospital; 2. the generally inadequate, unsatisfactory, and, at times, degraded conditions of many nursing homes; 3. the need for more hospital beds; 4. the borderline group ineli-

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gible for charity and too poor for satisfactory private care; 5. the rising cost of care in every field of medical service; and 6. the great gaps in insurance coverage?

We already have established committees to investigate and inform our members—but, unless we become truly organized, nothing will be done. For those still talking public relations—let a public awareness of our fight for better patient care be our best public-relations campaign; and in the last analysis, the only kind of program that will convince anyone of our sincere motives and encourage the public to look to us, instead of politicians, for counsel.

Richard T. Shaar, M.D.
Monthly Bulletin
Duval County Medical Society
June 1961

BLUE SHIELD

Sixteenth Annual Meeting

"At this, our sixteenth annual meeting of the Corporate Body of Blue Shield of Florida, Inc., we must come face to face with many serious problems which will determine the course and the future of Blue Shield." Thus was an unequivocal challenge tossed to participating physicians in Florida by President Russell B. Carson, M.D., keynoting his annual report to the active members on May 25, at the Americana Hotel, Bal Harbour, Miami Beach.

These serious problems were spelled out by Dr. Carson in the form of immediate objectives which must be aggressively pursued in the coming year if Blue Shield is to maintain its leadership in providing protection against the expenses of illness and fulfil its obligations to the people of Florida. Included among these are the development of more nearly uniform contracts throughout the nation with reasonable standardization of scope-of-benefits; flexible service income levels based on percentage of average annual income, rather than fixed dollar amounts; and the development and implementation of realistic protection for the senior citizens of the state, at a rate well within their ability to finance.

All officers were re-elected to their respective offices, including a seventh term as president for Dr. Carson. Other officers are: Drs. George S. Palmer, Tallahassee, and Jere W. Annis, Lakeland, vice presidents; Drs. John T. Stage, secretary, Floyd K. Hurt, treasurer, and Samuel M. Day, assistant treasurer, all of Jacksonville; and Mr. H. A. Schroder, assistant secretary, Jacksonville, who also serves in the capacity of executive director and who recently completed 25 years of service in the Blue Cross-Blue Shield movement.

Re-elected to the Board of Directors were Drs. Palmer and Stage; Mr. Carl G. Rose, Ocala; and Mr. Arthur Saarinen, Fort Lauderdale. New members of the Board are: Dr. James T. Cook Jr., Marianna, selected by the American Medical As-

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sociation as the General Practitioner of the Year for 1960; Dr. Ralph W. Jack, Miami, past president of the Florida Medical Association; Dr. John S. Stewart, Fort Myers, who for several years has been an active member of the Florida Medical Association's Advisory Committee to Blue Shield (Committee of Seventeen); and Mr. Horace F. Cordes, a retired businessman residing in Coral Gables. Newly elected to the executive committee is Board member Dr. W. Dean Steward of Orlando.

Other members of the Board of Directors are the officers: Drs. Carson, Annis, Hurt and Day, and Mr. Schroder. In addition are: Drs. Henry J. Babers, Gainesville; Norval M. Marr, St. Petersburg; John D. Milton, Miami; and William C. Roberts, Panama City; and nonphysician members William Hollis, Lakeland; C. Dewitt Miller, Orlando, who is also president of Blue Cross of Florida; H. P. Osborne Jr., Jacksonville; and Judge Ben C. Willis, Tallahassee.

Honorary members of the Board are: Dr. Leigh F. Robinson, Fort Lauderdale, first president and affectionately known as Mr. Blue Shield; and H. P. Obsorne Sr., active Board member and legal counsel for many years, who still serves the Plan in a legal capacity.

Board members serving on the executive committee, in addition to Dr. Steward, are: Drs. Carson, Marr, Milton, Palmer and Stage, and Mr. Saarinen, a Fort Lauderdale banker.

NEWS & PERSONALS

The Postgraduate Obstetric-Pediatric Seminar, sponsored by the State Health Departments of Florida, Georgia, South Carolina and Alabama, and the Florida Academy of General Practice, will be held August 17-19 at the Colonial Inn at St. Petersburg Beach. Scheduled to appear on the program are Dr. Robert Barter, Professor of Obstetrics and Gynecology, George Washington University School of Medicine; Dr. Bayard Carter, Professor of Obstetrics and Gynecology, Duke University School of Medicine; Dr. W. H. Laupus, Associate Professor of Pediatrics, Medical College of Georgia; Dr. Franklin J. Evans, Associate Professor of Legal Medicine, University of Miami School of Medicine; Dr. Richard T. Smith,

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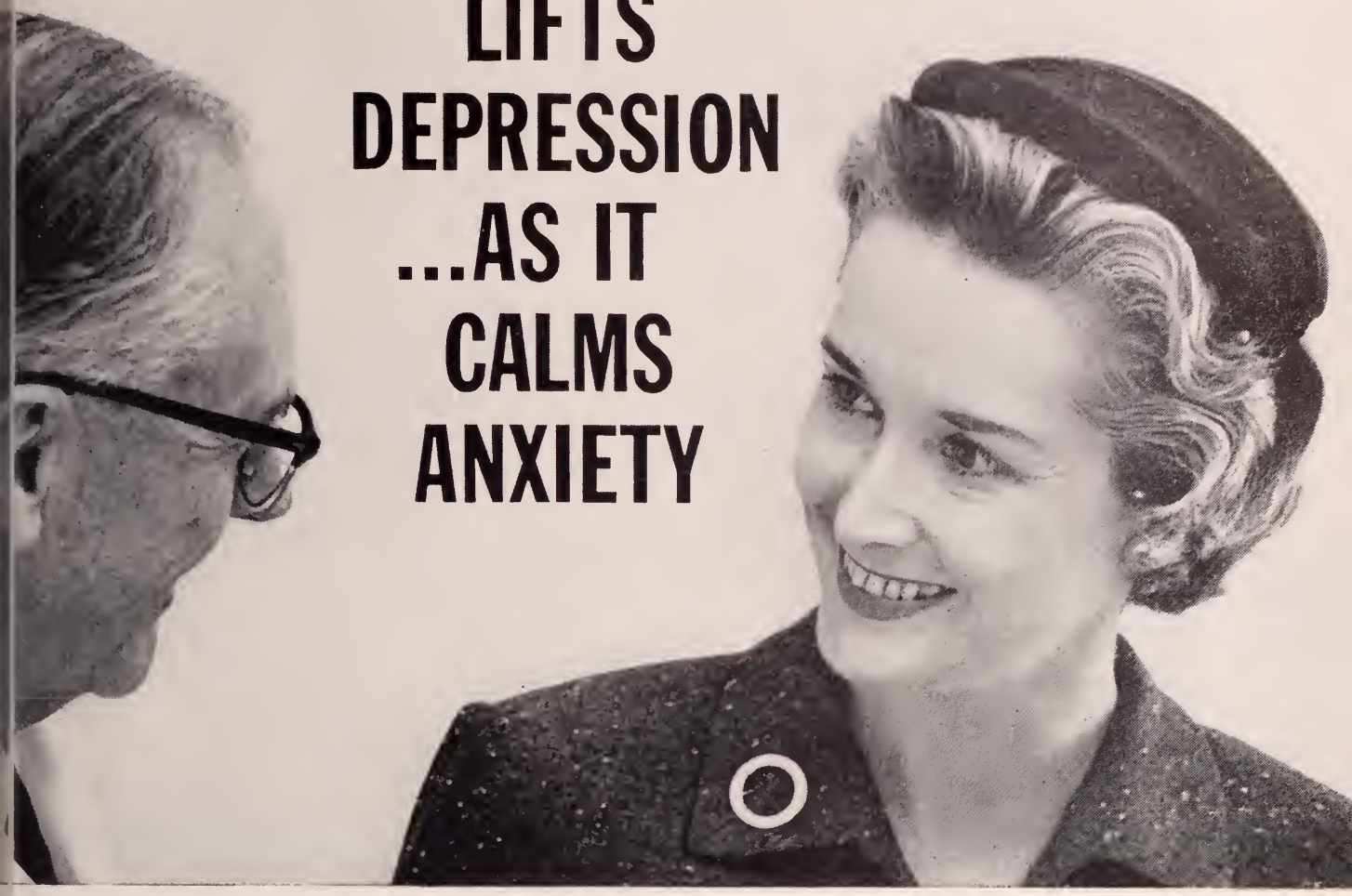
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Professor and Chairman, Department of Pediatrics. University of Florida College of Medicine; Dr. Marvin Hardin, Senior Attending Psychiatrist, Tampa General Hospital, and Mr. Edwin Rood, an attorney from Tampa.

There will be no registration fee, and physicians are urged to make their reservations directly with the Colonial Inn at St. Petersburg Beach.

Dr. Perry A. Sperber of Daytona Beach has been appointed a member of the Committee on Contactants of the American Academy of Allergy. He is a member of the Dermatology Committee and of the New and Unused Therapeutics Committee of the American College of Allergists.

Dr. S. Carnes Harvard of Brooksville, President of the Florida Medical Association, was principal speaker at the banquet of the Eighth Annual Meeting of the Florida Medical Assistants Association held June 2-4 at Miami Beach. The title of Dr. Harvard's address was "Coming Events Cast . . ."

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Florida Medical Association, addressed the Senior Class of the University of Miami School of Medicine on May 25. Dr. Day's discussion was entitled "Organized Medicine: Its Principles and Problems."

Dr. Richard T. Smith of Gainesville, Professor of Pediatrics at the University of Florida College of Medicine, was principal speaker for the May meeting of the Polk County Medical Association held at the Lakeland Yacht Club. Dr. Smith's subject was "Perspectives in Management of Infectious Diseases."

Dr. Minas Joannides of St. Petersburg Presented a paper entitled "Current Management of the Various Types of Emphysema" at the meeting of the Florida Thoracic Society held recently in Jacksonville.

Dr. Edward R. Annis of Miami addressed the House of Delegates of the Texas Medical Association at a luncheon during the recent annual meeting in Galveston.

Drs. Shaler Richardson and Charles W. Boyd of Jacksonville attended the meeting of the Ameri-

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can Ophthalmological Association the first of June at The Homestead in Hot Springs, Va.

Dr. Jere W. Annis of Lakeland was a member of the panel presented as a part of the program of the Public Affairs Seminar sponsored by the Florida Conference on Small Business at Tampa May 23. Dr. Annis discussed "The Socialistic Challenge in Medicine."

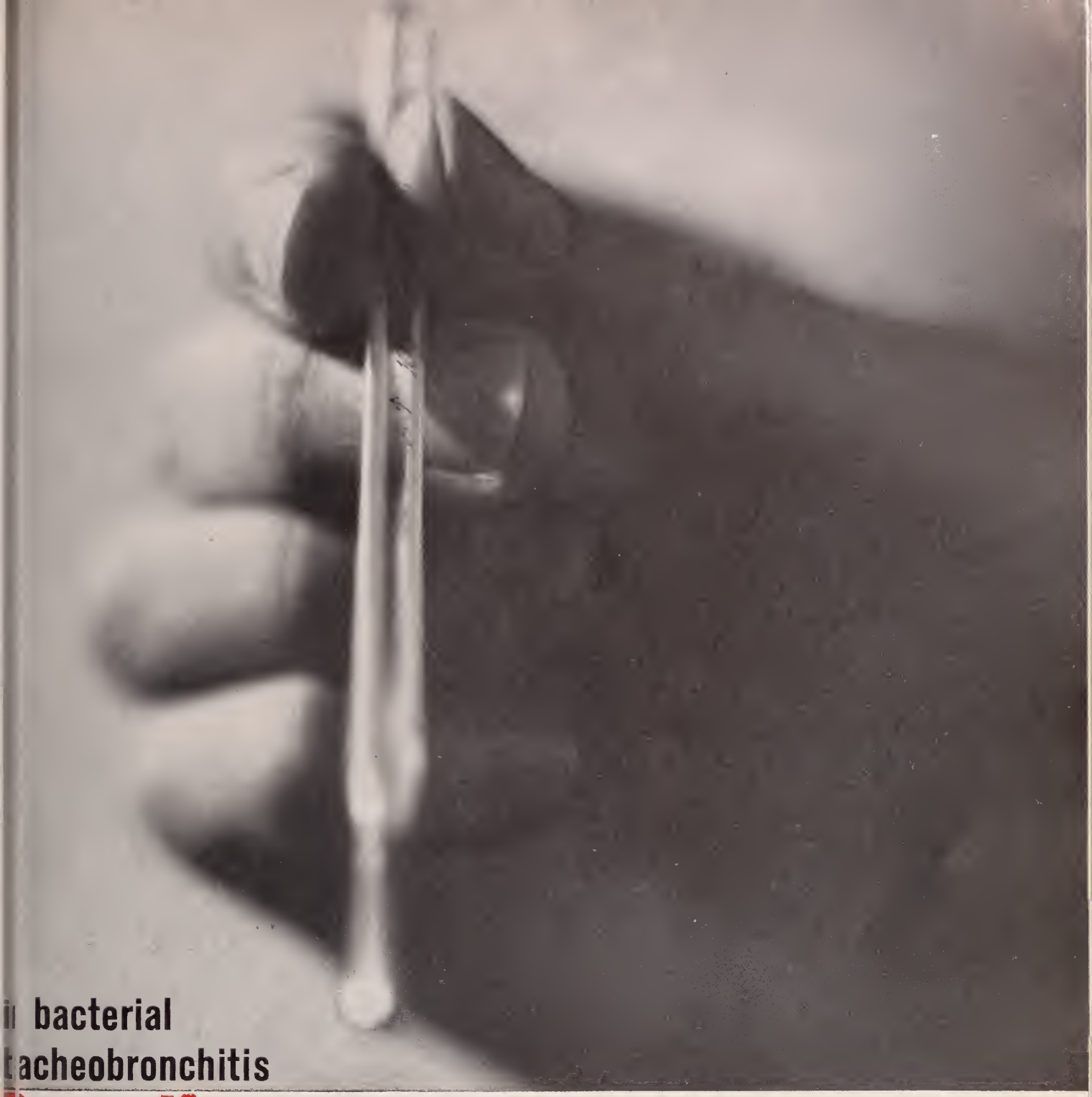
Dr. Frank P. Murphy of Lakeland was principal speaker at a recent meeting of the DeSoto-Hardee-Glades County Medical Society held at Arcadia. Twelve members were present for the program on "Practical Office Orthopedics."

Dr. Jere W. Annis of Lakeland has been appointed a visiting instructor by the University of Miami School of Medicine.

Drs. Burns A. Dobbins Jr. of Fort Lauderdale, Thomas C. Dickinson of Orlando, Philip Samet of Miami Beach and Robert S. Litwak of Miami appeared on the program of the Eighth Annual Meeting of the Florida Medical Assistants Association held June 2-4 at Miami Beach. Dr. Dobbins discussed "The Doctor and Health Insurance," Dr. Dickinson "Laboratory Procedures for Diagnosis—Procedures Prior to Catheterization and Heart Surgery—What Are They?—What Are They For?" Dr. Samet "Cardiac Catheterization," and Dr. Litwak "Open Heart Surgery."

The Broward County Medical Association has appointed a Voluntary Health Insurance Review Committee to work with the Committee on Commercial Health Insurance of the Florida Medical Association in settling disputes between insurance carriers and physicians and patient-physician problems concerning health insurance coverage. The committee will be permanent under the Committee on Insurance Plans, and Dr. David J. Lehman Jr. of Hollywood is chairman.

The Putnam County Medical Society has raised by voluntary assessment of its members a fund for two scholarships to be presented to a student at the St. Johns Junior College and to a Negro student at the Collier-Blocker Junior College. The first scholarship was presented to Jay Scott Major, attending St. Johns Junior College, by Dr. Lawrence G. Hebel of Palatka who represented the Society.



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Dr. Benjamin B. Wells of Washington, D. C., Director of Research and Education, Department of Medicine and Surgery, Veterans Administration, was principal speaker at the May meeting of the Pinellas County Medical Society. The title of Dr. Wells' presentation was "Laboratory Studies in Pancreatic Disease."

Dr. Edward R. Annis of Miami accepted the invitation of the Louisiana State Medical Society to be Annual Orator at its Eighty-First Annual Meeting in New Orleans May 8-10. On Monday evening, May 8, Dr. Annis addressed members of the Society on the subject "Medical Aid for the Aged."

Drs. Mark W. Wolcott, J. Harold Medlin and Asher Marks of Miami appeared on the program of the joint annual meeting of the National Tuberculosis Association, American Thoracic Society and National Conference of Tuberculosis Workers held May 21-25 at Cincinnati, Ohio.

OBITUARIES

Louis McDonald Orr

Dr. Louis McDonald Orr of Orlando died suddenly at his home on May 23, 1961 of coronary occlusion. He was 61 years of age.

Born at Cummings, Ga., on Sept. 27, 1899, Dr. Orr spent his earliest years in Greensboro, Ga., and Dothan, Ala. He attended elementary school and high school at Glynn Academy in Brunswick, Ga. In 1921 he received the degree of Bachelor of Science from Emory University in Atlanta, Ga., and in 1924 the Emory University School of Medicine conferred on him the degree of Doctor of Medicine. He was graduated near the top of his class and was a member of the Caduceus and Asklepios honor societies and Phi Rho Sigma and Phi Delta Theta fraternities. He then served an internship at Peter Bent Brigham Hospital in Boston, Mass., which was followed by a residency in urology and general surgery at the old Lakeside Hospital in Cleveland, Ohio.



In February 1927, Dr. Orr entered the private practice of medicine in Orlando. His specialty was urology, and he was a consultant in urology and director of graduate education at Orange Memorial Hospital at the time of his death. Locally, he was identified through the years with many civic and social activities, among them the Central Florida Civic Music Association, which he served as president from 1939 to 1952. He was chairman of the Municipal Auditorium Committee, and also of the Loch Haven Park Board at one time. In 1938, through the generosity of Dr. and Mrs. Orr the fourth blood bank in America was established at Orange Memorial Hospital. The Louis M. Orr Foundation for Cancer Research has an executive board composed of prominent Florida citizens. For 14 years Dr. Orr served as a trustee of Rollins College in nearby Winter Park. A devout churchman, he was a member of the Episcopal Cathedral Church of St. Luke in Orlando. He held membership in the Country Club of Orlando, the Mountain Lake Club and the Colony Club.

For more than three decades Dr. Orr had held membership in the Orange County Medical Society, serving at one time as secretary and twice as president. He was for many years a delegate from that society to the House of Delegates of the Florida Medical Association.

From the outset of his career Dr. Orr was an active member of the Florida Medical Association. His first office was that of Associate Editor of The Journal, a post he held continuously from 1933 to 1959. Through the years he served as Councilor for his district and on various regular and special committees including the Committee on Scientific Assembly and the Committee on Venereal Disease Control. He was a member of the Association's House of Delegates from 1948 to 1957 and served seven years as chairman of the Credentials Committee. In 1954 he was a member of the Board of Governors. From 1948 to 1957 he served the Florida Medical Association with great distinction as one of its representatives in the House of Delegates of the American Medical Association.

Dr. Orr had a distinguished career with the American Medical Association before he was elected to office in that organization. He served as chairman of the Committee on Federal Medical Services, as an ex officio member of the Council

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on Constitution and By-Laws and as a member of the Council on Medical Service. In 1955 he was elected vice speaker of the House of Delegates and continued to serve in that capacity until he became president-elect in 1958. In 1959-1960, Dr. Orr, the first Florida physician ever to be so honored, served as the 113th president of the American Medical Association and proved himself a strong opponent of any system of government medicine. During his tenure of office he carried out one of the busiest traveling and speaking schedules ever attempted by an officer of the American Medical Association. In his capacity as president he spoke in almost every state and visited the Far East, Europe, Canada and Brazil. At the time of his death, he was chairman of the Commission on the Cost of Medical Care and also held membership on the Council on Medical Services and the Committee on Federal Medical Services.

Dr. Orr was also a member of the American Association of Genito-Urinary Surgeons, American Urological Association, Southern Medical Association, American College of Surgeons, Association of American Physicians and Surgeons, Southeastern Surgical Congress, International Society of Urology, World Medical Association and Society of Nuclear Medicine. He was a founding member of the American Board of Urology in 1936. In 1943 he was president of the Southeastern Section of the American Urological Association. He was the recipient of the Algernon Sydney Sullivan Award, Rollins College's highest honor, in 1946, and in 1960 he was awarded an honorary degree of Doctor of Science by Emory University, his alma mater. He was on the consulting staff of the Institute of Nuclear Studies, Medical Division, at Oak Ridge, Tenn. As a member of the board of directors of the United States Committee of the World Medical Association, he attended the Eleventh General Assembly in Istanbul, Turkey, in 1957. His contributions to the scientific literature of medicine number more than 50, and he was active in the Florida Medical Committee for Better Government.

In July 1942 Florida's most distinguished medical citizen entered military service in World War II. He rose from major to full colonel in the Army Medical Corps and was executive officer and later commanding officer of the 15th Hospital Center, European Theatre of Operations, from 1943 to 1945, with headquarters in Cirencester, England. He was awarded the Bronze Star for

(Continued on page 112)

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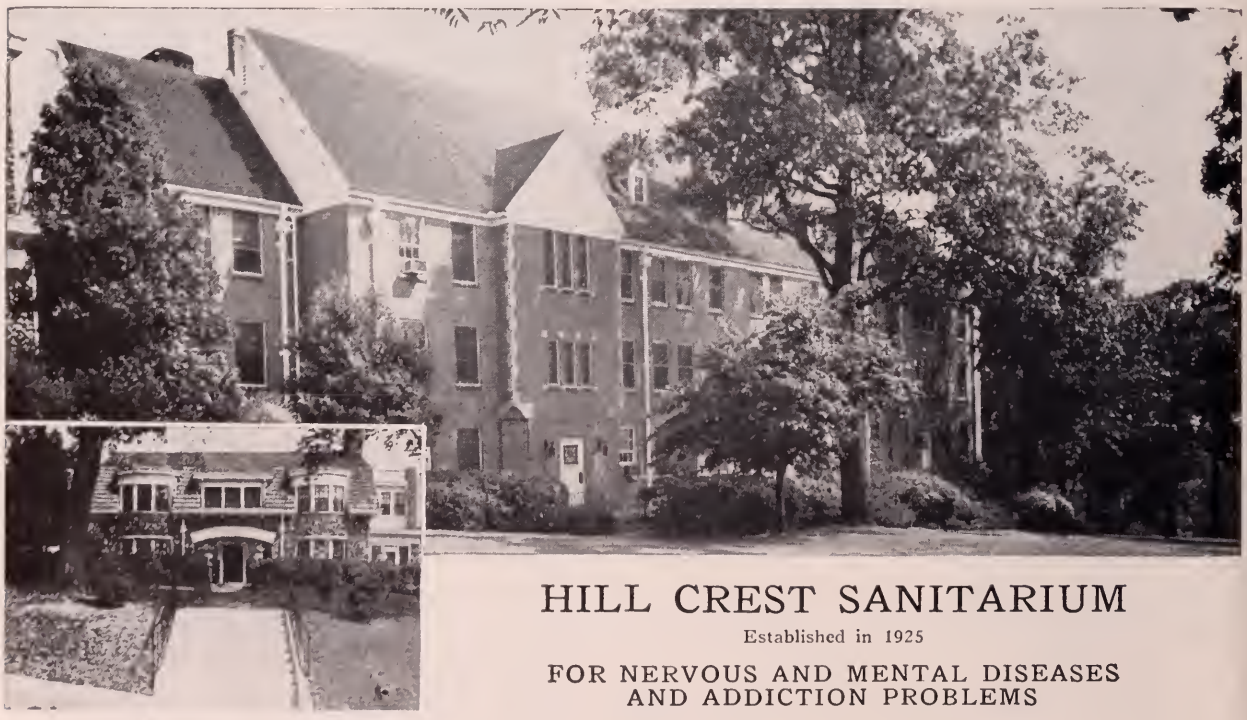
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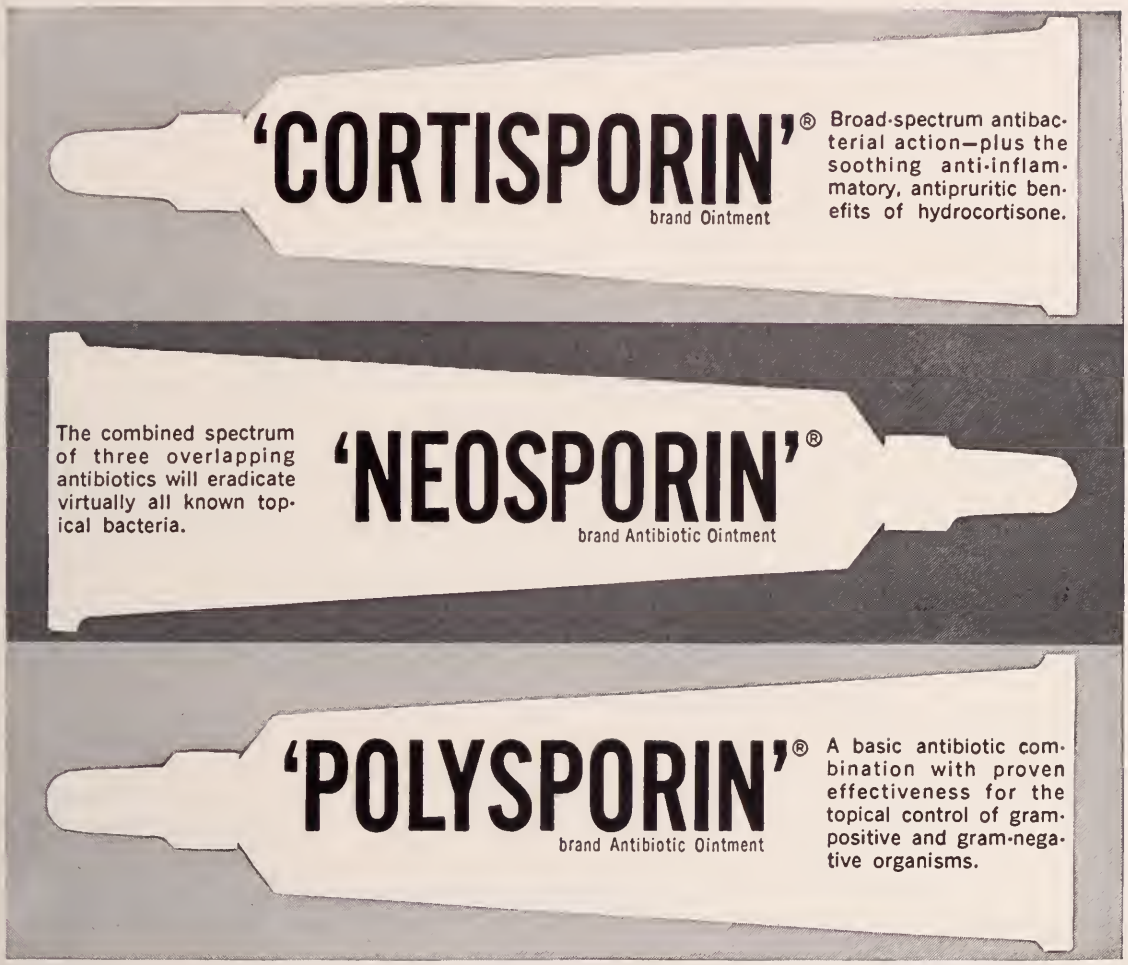
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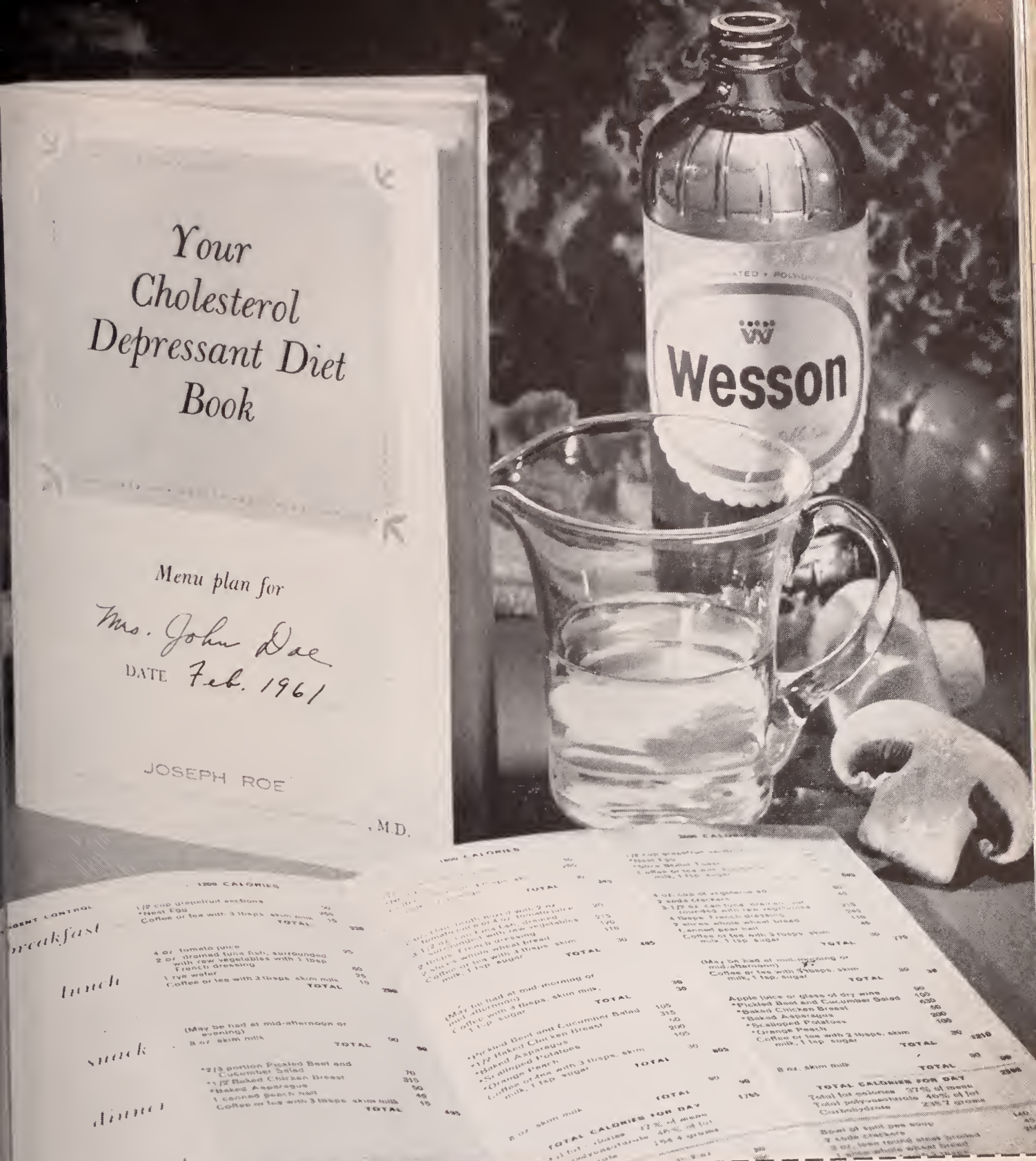
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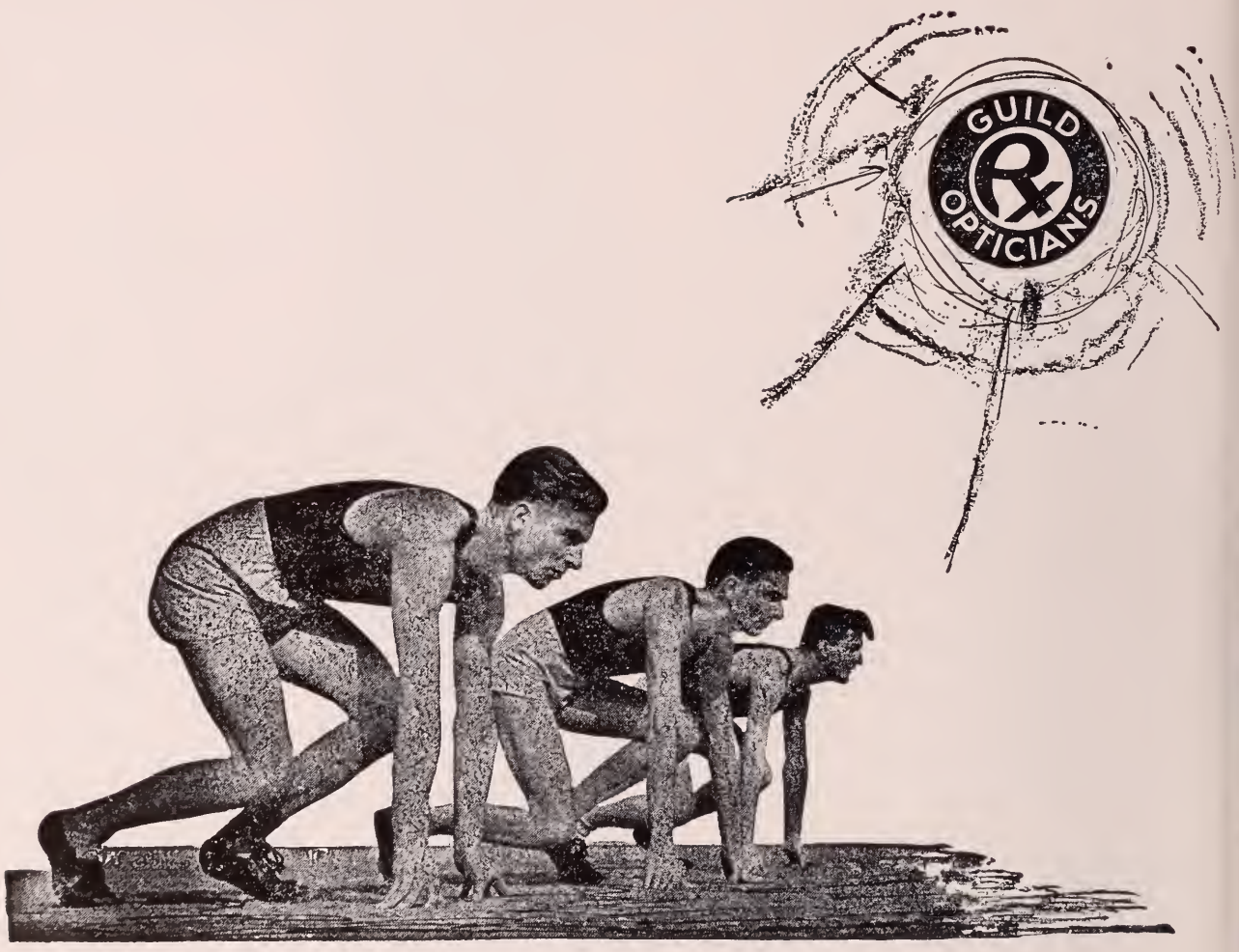
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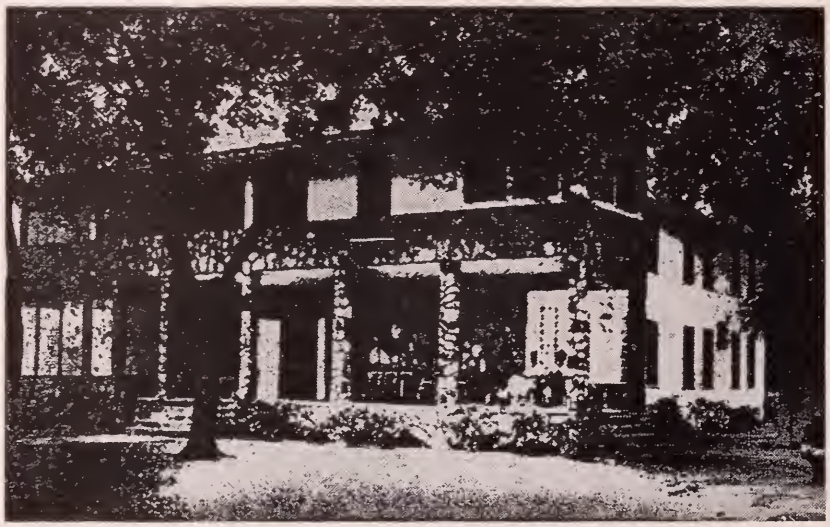
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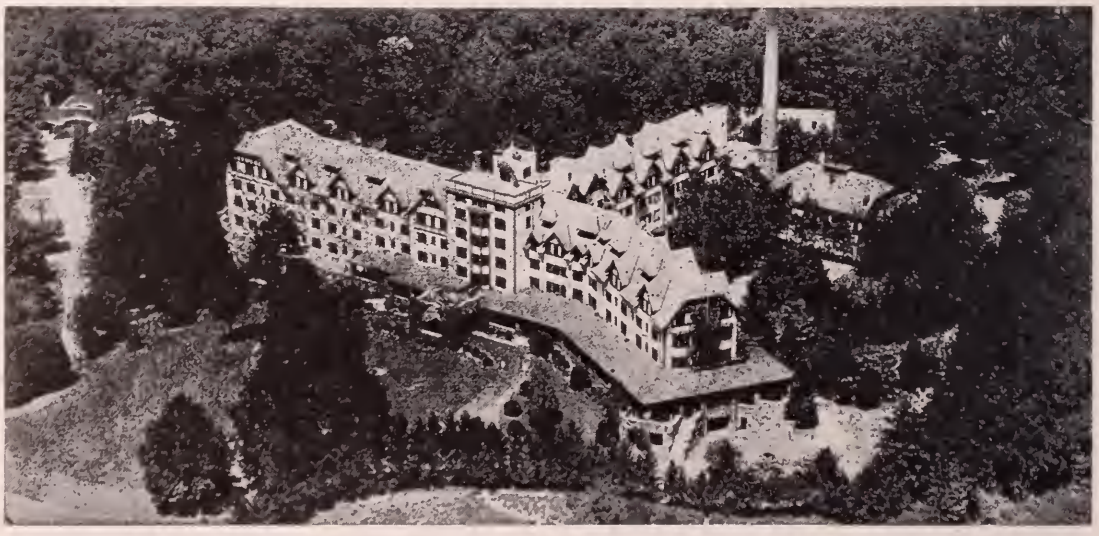
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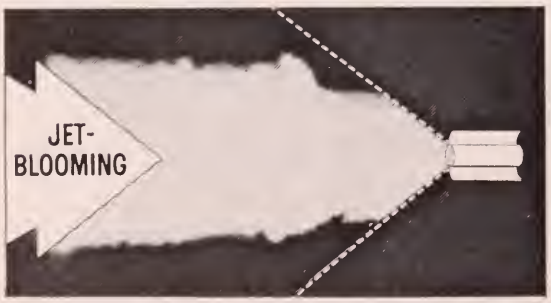
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Woman's Auxiliary

Theme for 1961-62

"TOGETHERNESS"

Each year we seem to choose a theme around which we try to plan our year's work. This year I have chosen one which is short, simple and easy to remember, but if all of us will try to plan with this thought in mind, our results will be long, far-reaching, and not forgotten.

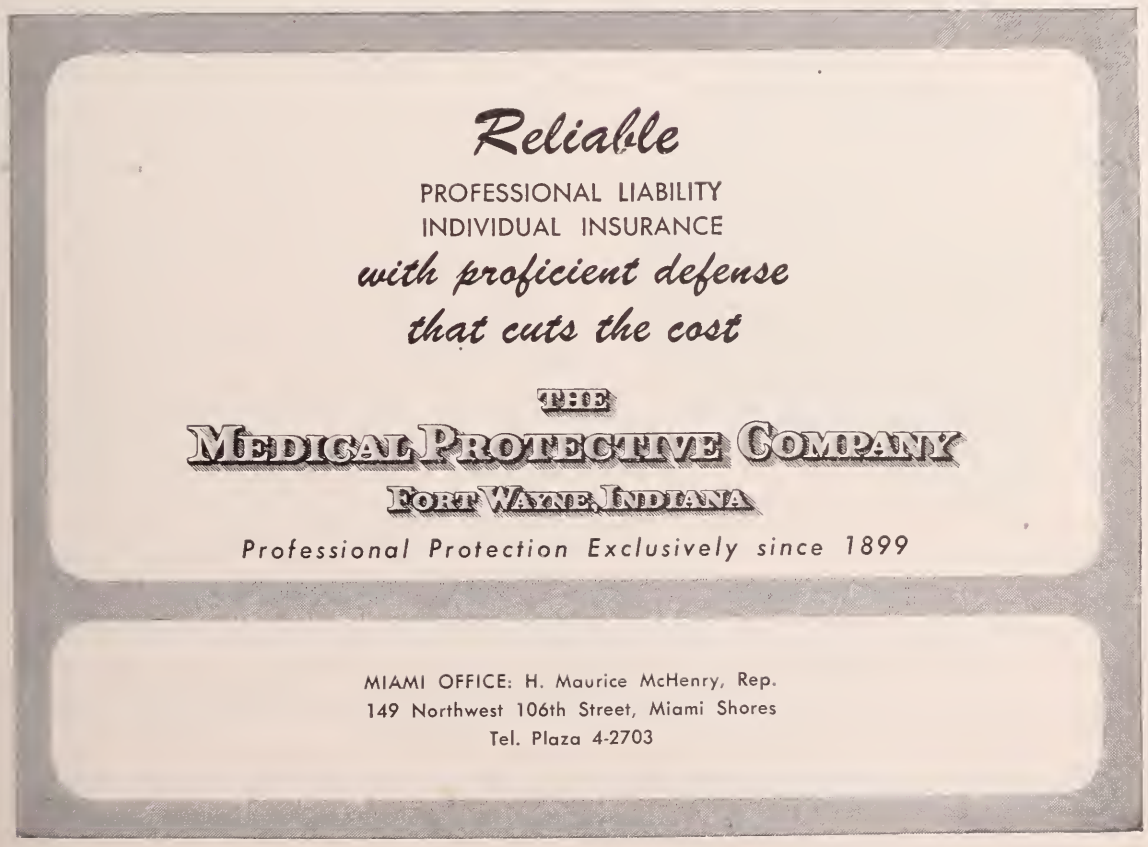
The theme I have in mind is "TOGETHER-NESS." There are three ways of accomplishing this state of being or belonging together which we are planning to try this year.

The first is in increasing our Membership. One of the aims of our auxiliary is to promote friendly relations among doctor's families—but how can we be friendly unless we know each other? Remember that through knowledge comes understanding, and through understanding comes friendship.

The second is to increase our service to the Medical Association. We are an AUXILIARY—we exist for the purpose of serving and promoting the aims of our County Medical Societies and the Florida Medical Association. Our first job at the beginning of a new year, is to check with our advisory committee to see if any specific jobs are needed. Sometimes we are told: "Anything you want to do is fine." We don't want this to be the end of our contact. We'll look around to see the health needs in the community, plan our program with these in mind, then check back again for a final okeh. Close cooperation between the county society and the auxiliary can accomplish great things.

The third way to experience "TOGETHER-NESS" is to work together for a common purpose. This year the vital issue is Legislation. We must all join hands in this endeavor. Let us see how much we can accomplish with a united effort! All of our auxiliary projects are good, but I sometimes feel that we tend to spread ourselves too thin and try to accomplish too many things at once. Perhaps we could benefit by the system used by the League of Women Voters.

We do have in our auxiliary a number of "Continuing Responsibilites" such as Health Careers, A.M.E.F., and the Florida Auxiliary Medical Education Fund, but then each year we could choose one field of service for "Current Emphasis" and all work together on the project



chosen for a particular year. The project would vary with the need, and this year we all feel that Legislation is the top priority job.

Only by educating ourselves and sharing our knowledge with our friends can we expect to help our husbands in their effort to maintain the present high standard of medical care.

Won't you join hands across the state of Florida, and put your "TOGETHERNESS" to work?

MRS. W. DEAN STEWARD
PRESIDENT

Obituary—Dr. Orr

(Continued from page 98)

outstanding service and after the war received many honors both in the United States and in Great Britain.

Survivors include the widow, the former Miss Dorothy Brown of Boston; a son, Louis M. Orr, III, M.D., now interning at Piedmont Hospital, Atlanta, Ga.; a daughter, Doris, a student at Finch College, New York City; a sister, Mrs. Dan Gill; and one grandson, Louis M. Orr, IV.

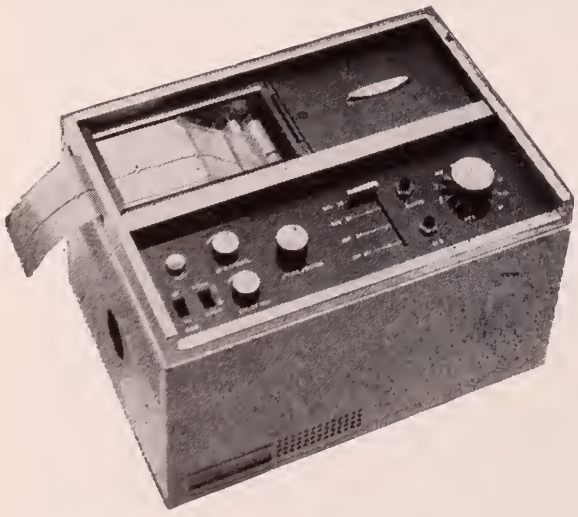
BOOK REVIEWS

Complications in Surgery and Their Management. Edited by Curtis P. Artz, M.D., F.A.C.S., and James D. Hardy, M.D., F.A.C.S. Pp. 1075. Illus. 272. Price, $23.00. Philadelphia, W. B. Saunders Company, 1960.

There is no question that experience is the best teacher and the best teachers are experienced. The two fine young surgeons who are responsible for this arduous task are already known for their talents and this volume is just another feather in their caps. The abstracter did not read this book in its entirety, but first thumbed each page and then perused the chapters he most desired. The contributing authors, too, should be commended on their individual merits as they are specialists in an "ultra" sense and have written on their favorite pursuits. The readers will find a discussion in general of all surgical complications when he first opens the book. As he turns the pages he will interest himself with complications regarding anatomic regions. The text is well planned, written in large type and supplemented with pictures, drawings and references. The authors advise that prevention of errors is the best treatment, but in case the complication is encountered, they suggest maneuvers to correct it. The surgical topic in general is covered very adequately. The book will be of interest mainly to the house physician, but others who teach or practice the surgical field would do themselves no harm to know its contents.

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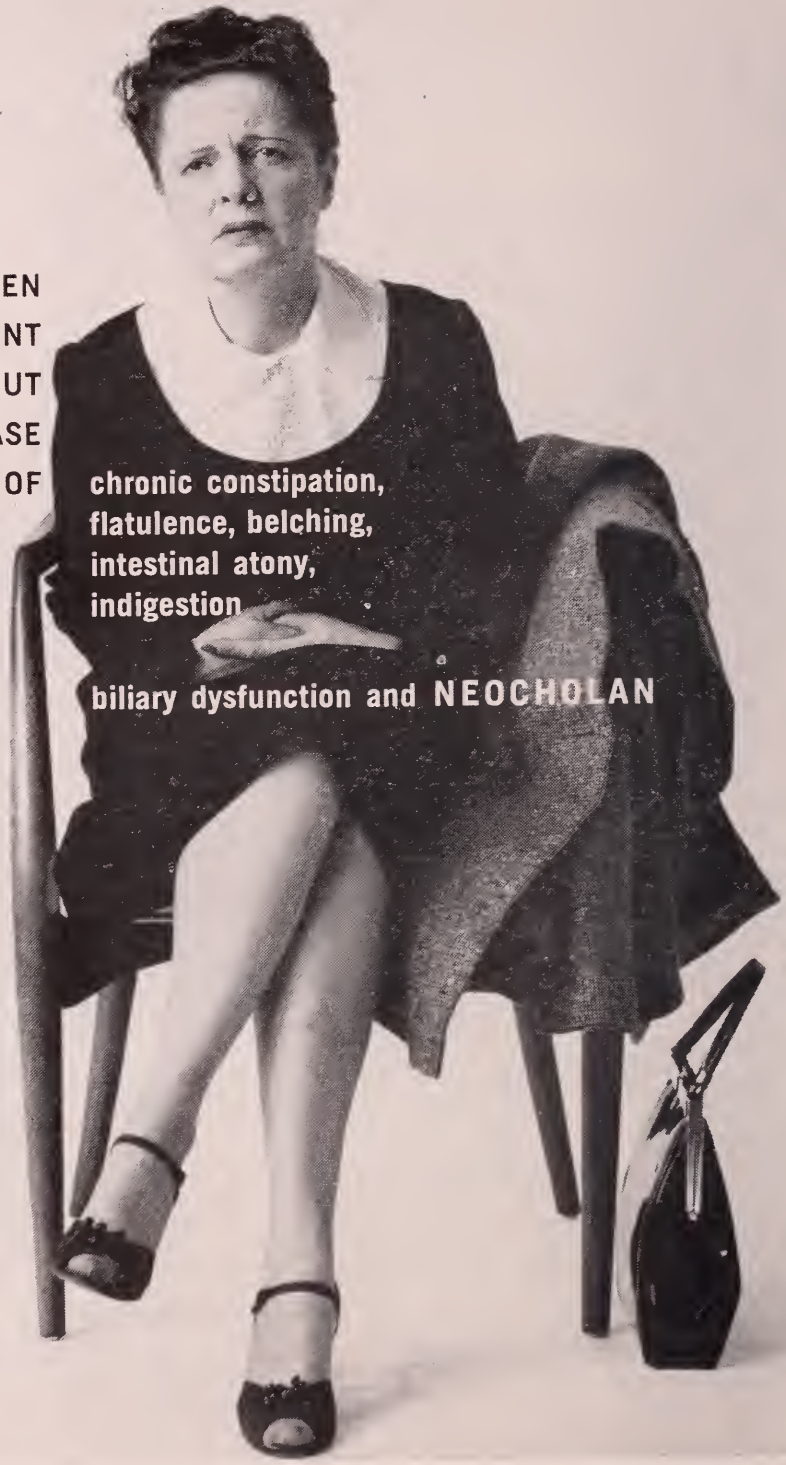
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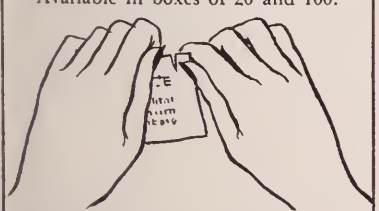
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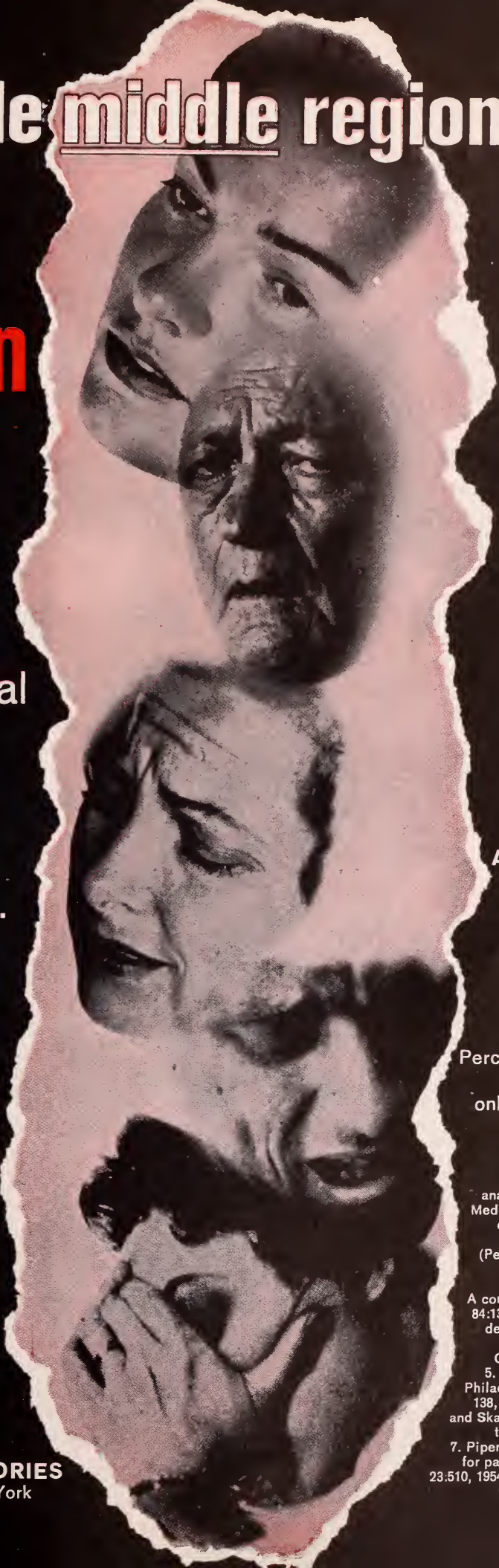
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., **et al.**: Diabetes 7:398, 1958.

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1. Kane, S.: Am. Pract. & Digest Treat. *8*:65 (Jan.) 1957.

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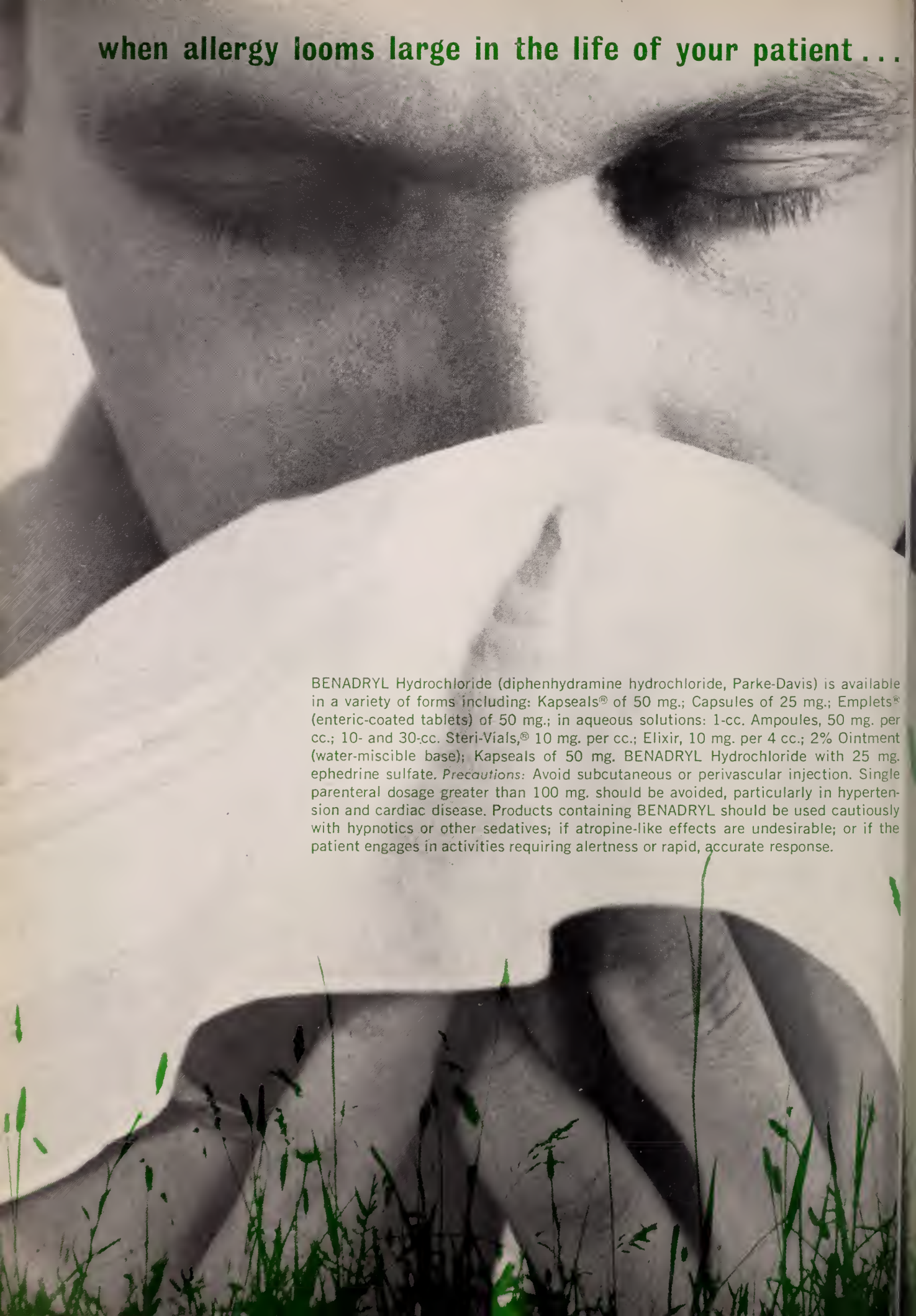
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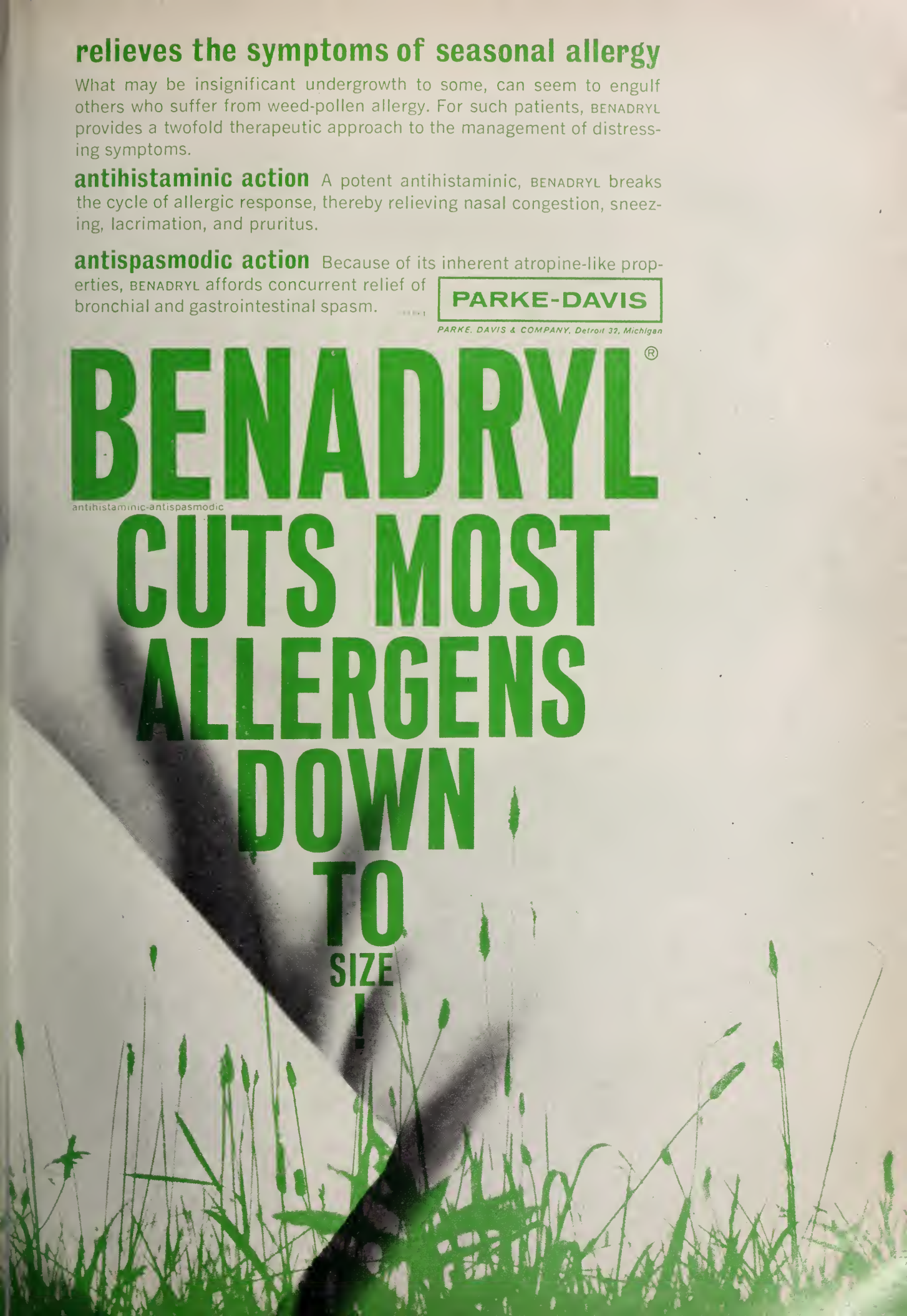
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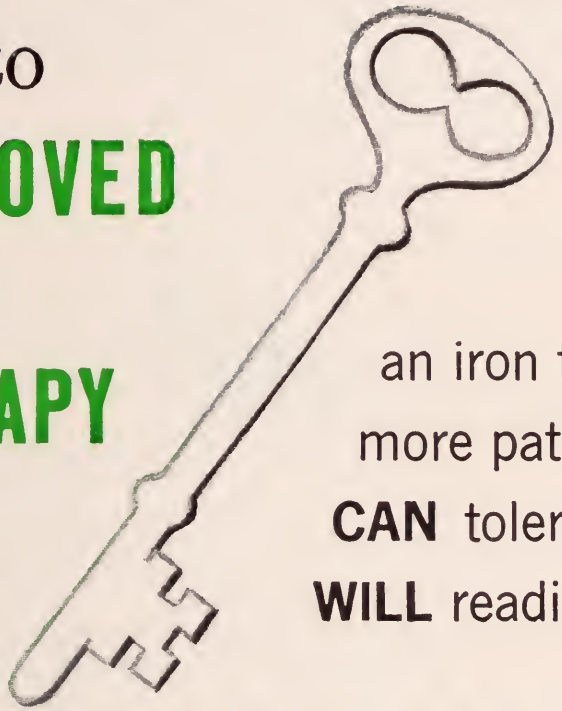


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Volume XLVIII, No. 2, August, 1961

Factors Peculiar to the Management of Fractures in Childhood

CRAWFORD J. CAMPBELL, M.D.
ALBANY, N. Y.

There are many factors which should affect judgment in the management of fractures and dislocations in the child. These have been stressed in previous publications both in textbooks and monographs on specific fractures. Much of this work has been included in a recent publication by Blount. It is the purpose of this paper to cover briefly a few of the more obvious differences to be considered when managing trauma to the bones and joints in a child as compared to an adult.

Problems in Diagnosis

Fractures and dislocations involving the epiphysis or epiphyseal plate may be difficult to diagnose in roentgenograms (figs. 1 and 2). The normal ossification center may be mistaken for a fracture fragment (fig.11b), or a fracture line may be invisible if it extends transversely across the cartilage at the epiphyseal plate or epiphysis. Usually a careful study of the opposite extremity and reference to illustrations showing the normal time of appearance of the centers of ossification will aid in the diagnosis. If the clinical examination suggests the possibility of a fracture and the initial roentgenogram does not show it, the injured extremity should be adequately splinted. Roentgenograms taken two or three weeks later may show the fracture or evidence of callus formation. In the differential diagnosis of fractures in children some of the following points should be considered:

1. A "growth arrest line" may be mistaken for a fracture. It is a line of increased density, transversely oriented in the metaphysis of the long bone. There is no defect in the cortical margin of the bone suggesting an infraction.

2. Stress or march fractures which occur in childhood may be difficult to recognize as fractures. They are usually located in the tibia or fibula. The fracture line is transverse and may be difficult to define. Often callus is first noted and may be mistaken for a tumor or infection.

3. The osteochondroses or aseptic necrosing lesions of bone such as Osgood-Schlatter's disease may be painful following a traumatic incident and should be differentiated from fractures (fig. 3). The location and age incidence of each of these disorders aid in the diagnosis. They are often bilateral so that a roentgenogram of the opposite extremity is indicated in questionable cases.

4. Congenital pseudarthrosis, pathological fractures both in tumors and metabolic diseases of bone, and anomalies of growth may occasionally present difficulties in diagnosis.

The Healing of Bone in the Growing Skeleton

Following a fracture in a child, there is early and abundant callus formation. Even if there is no bony contact, there will be good healing if there is no mechanical obstruction to the growth of the callus between the bone ends. Every effort should be made to maintain the alignment and normal rotation of the bone fragments. The most common cause of pseudarthrosis following a fracture in a child is surgical intervention. The risk

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of complications such as delay in healing and infection makes surgical intervention unwarranted except when specifically indicated as in a displaced fragment involving a joint surface which cannot be reduced by closed methods.

The Remodeling of Bone in the Growing Skeleton

Once healing of a fracture occurs, there is a remodeling of the trabeculae and cortex along lines of stress. This process is accelerated and is more pronounced in children than in adults. A degree of displacement or angulation much greater than that in an adult is acceptable since it may correct itself spontaneously (fig. 4). Generally the younger the child and the nearer to the end of the bone, the more angulation one may accept (fig. 5). Conversely, the older the child and the nearer the fracture is to the middle of the bone, the more accurate the reduction must be (fig. 6).

The Effect of Trauma on the Epiphyseal Plate

Occasionally a fracture of a long bone may temporarily stimulate growth at the epiphyseal plate so that an inequality of length will exist between the two limbs. Although this can be carefully measured, it is seldom sufficient to make the wearing of lifts necessary in the shoe or to cause disability.

Although fractures frequently extend into the epiphyseal plate, growth retardation of clinical significance seldom occurs. Most fractures in the metaphysis of the long bone which extend to the epiphyseal plate cross the plate in the natural line of cleavage through the zone of hypertrophied or calcified cartilage (fig. 7). This type of fracture does not affect those cartilage cells on the epiphyseal side of the plate which are responsible for continued growth. Occasionally a fracture will cross the plate longitudinally and ex-



Fig. 1. — The dislocation of the head of the radius was not diagnosed in roentgenograms taken six months previously, at which time this 10 year old child was treated for a fracture of the proximal third of the ulnar. This was initially a Monteggia fracture.



Fig. 2.—The roentgenograms of the thoracic and lumbar spine of this 6 year old child show many irregularities of growth (Calvé's disease, epiphysitis). These films show no evidence of fracture in the low lumbar spine resulting from a fall off a swing two hours previously. There was no evidence of a fracture on clinical examination, and within 24 hours there was no persistent pain. An epiphysitis of the lower thoracic and upper lumbar spine is often mistaken for a fracture.

tend into the epiphysis (fig. 8). Such a fracture is not repaired with cartilage resembling the epiphyseal plate, but with fibrous tissue and bone (figs. 9a and b). If the fracture line is linear and the resulting bony bridge small, the growth of the plate may not be affected or may be only minimally altered. On the other hand, if there is a large compressive force so that the full thickness of the plate is extensively involved, a large osseous bridge may form between the epiphysis and mephysis and growth retardation occur. For this reason it is necessary to reduce a fracture of this type gently and accurately.

Growth retardation may affect the growth in length of the long bone, or it may be noticed as an angulation deformity. Periodic examinations



Fig. 3. — This roentgenogram of a 13 year old girl's knee shows typical Osgood-Shlatter's disease. There was an infraction of the tibial tubercle. Notice the increased density in the distal tip indicating an aseptic necrosis.



Fig. 4. — Serial roentgenograms of a 12 year old boy show an excellent remodeling with subsequent normal appearance and function in this imperfectly reduced fracture of both bones of the forearm. The younger the child and the closer to the end of the long bone, the greater the angulation or displacement which may be accepted. The time interval from the initial fracture to the final results as seen in these roentgenograms is six months.



Fig. 5.—a. Attempts for one week to reduce this fracture of the surgical neck of the humerus by manipulation and traction in a 13 year old girl had been unsuccessful. Subsequent treatment consisted of the use of a sling and swathe with early circumduction exercises. A subsequent roentgenogram (b) made one year later shows an excellent remodeling. There was no limitation of motion.

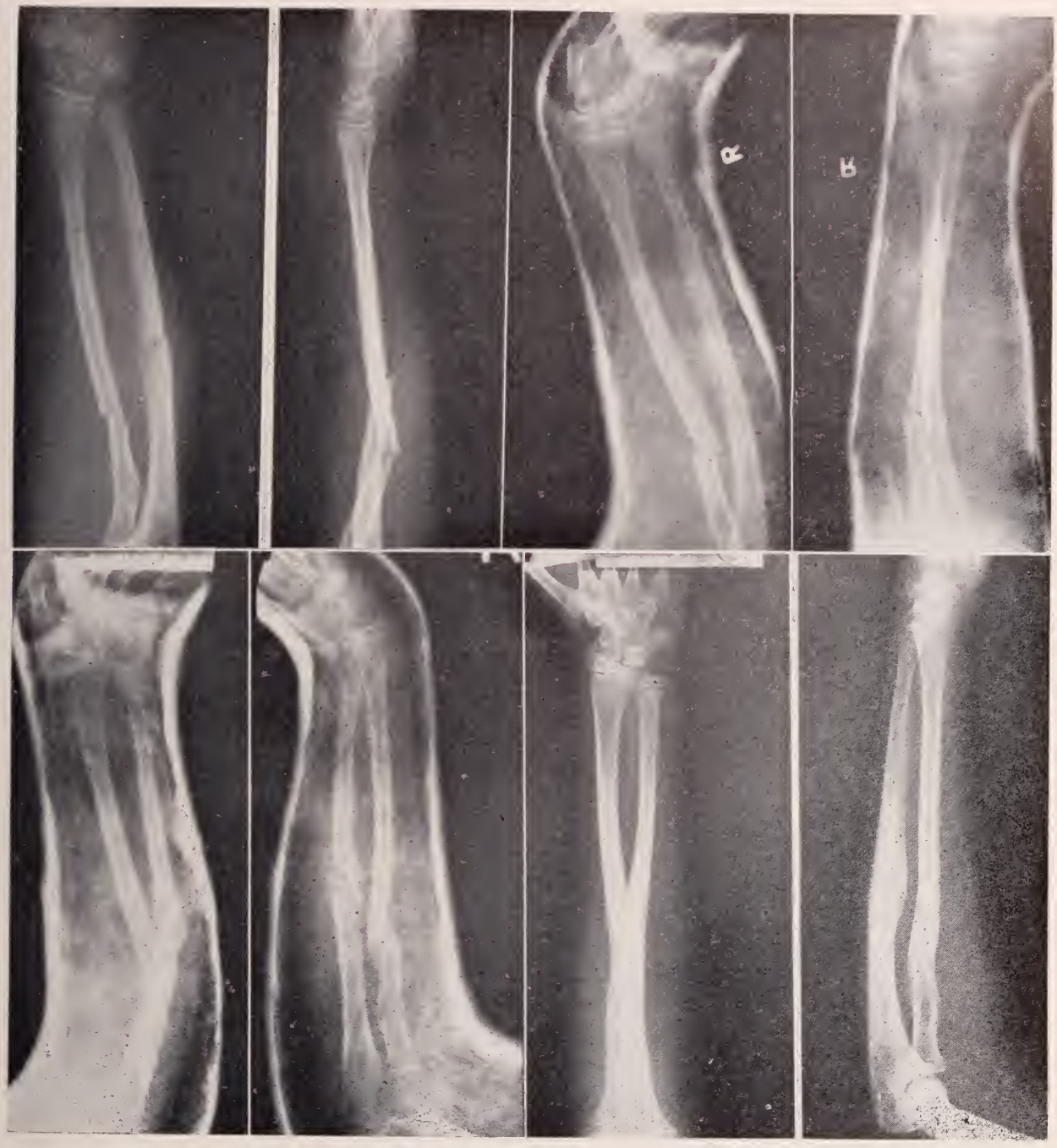


Fig. 6. — Both a and b show only slight correction of an angular deformity in a fracture of the radius and ulna. The fracture of the radius was in the proximal third and was proximal to the insertion of the pronator teres. The forearm was incorrectly immobilized in a position of neutral rotation in a long arm plaster cast with a subsequent marked increase in deformity two weeks later (c) so that another manipulation with immobilization of the forearm in full supination was accomplished. An angulation and deformity of this degree were not acceptable in this 14 year old boy.

for limb length and serial roentgenograms at three month intervals are indicated until the rate and direction of growth of the affected bone is ascertained.

Open Reduction in Fractures in Childhood

Open reduction is seldom necessary in children. It is indicated in fractures involving the joints when closed reduction has failed. It has occasionally been used in our institution for the following:

1. Fractures of the medial and lateral epicondyles of the humerus (fig. 10). The fragment is placed in its anatomical position and internally fixed with a Kirschner wire. The wire does not extend through the skin and is removed after three weeks.



Fig. 7.—The roentgenograms of the distal tibia and fibula in this 13 year old boy show a fracture extending transversely across the epiphyseal plate. An excellent reduction was obtained by gentle manipulation under a general anesthetic. There was no subsequent growth retardation.



Fig. 8.—Serial roentgenograms of the distal tibia and fibula show an angulation deformity caused by growth retardation and arrest of the distal epiphyseal plate in an oblique fracture crossing the full thickness of the plate.

2. Fractures through the neck of the radius with displacement of the head. The head of the radius is never removed in a child, but is replaced in its normal position (fig. 11).

3. Monteggia fracture. This fracture can usually be reduced by closed methods in children. Care should be taken to reduce the dislocation of the head of the radius. If the ulnar fragments cannot be maintained in good position, a Kirschner wire can be used for intramedullary fixation for three weeks.

4. Avulsion of the tibial spine. This should be anatomically reduced.

5. Displaced cartilaginous or osteocartilaginous fragments into a joint. The differential diagnosis in such cases must include osteochondritis dissecans and osteochondromatosis. An arthrotomy with removal of a displaced fragment should be performed.

General Principles of Treatment

1. If traction is necessary in the maintenance of alignment as in a fracture of the femur, circumferential bandages must be systematically checked to avoid obstruction to the circulation. Volkmann's ischemia can occur in the foot as well as the hand, and has been observed occasionally following incorrectly applied Bryant's traction.

2. Traction is discontinued when there is adequate callus formation both on roentgenographic and clinical examination, and a plaster cast is applied.

3. Plaster immobilization should be more extensive than in adults, including the joint above and the joint below the fracture. There should be no haste, particularly in fractures of both bones of the forearm, femur, and tibia, in removing the cast since subsequent mobilization of joints and muscle training are not a difficult problem in children.

4. Once the cast is removed, the child will automatically stand, move, and exercise as quickly as possible so that no special physiotherapy is necessary. Any stretching or forcing of joints should be avoided.

Summary

The processes of healing and remodeling following fractures are more rapid in the child than in the adult.



Fig. 9a. — A photomicrograph (x4) shows a defect in the epiphyseal plate three weeks following an osteotomy in the distal radius of a three month old puppy. Such a defect does not fill in with cartilage, but with fibrous tissue and bone.

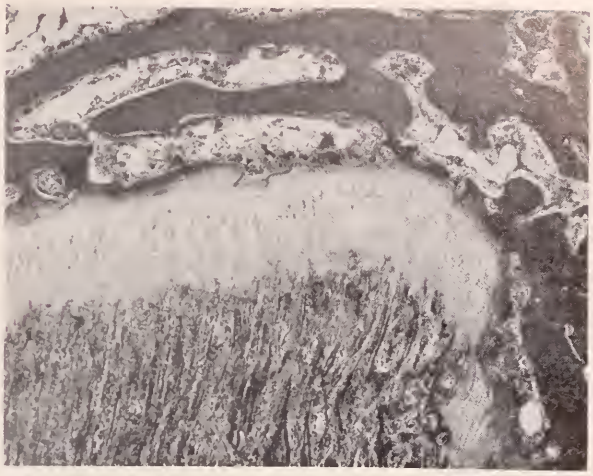


Fig. 9b.—A higher magnification (x43) shows the osseous bridge in the defect. There is invagination of the plate into the metaphysis with some disturbance of growth. The amount of growth retardation depends on the size of the focal destruction in the plate. This is caused by (1) the strength of the osseous bridge and (2) lessened growth force due to the destruction of some of the plate responsible for growth.

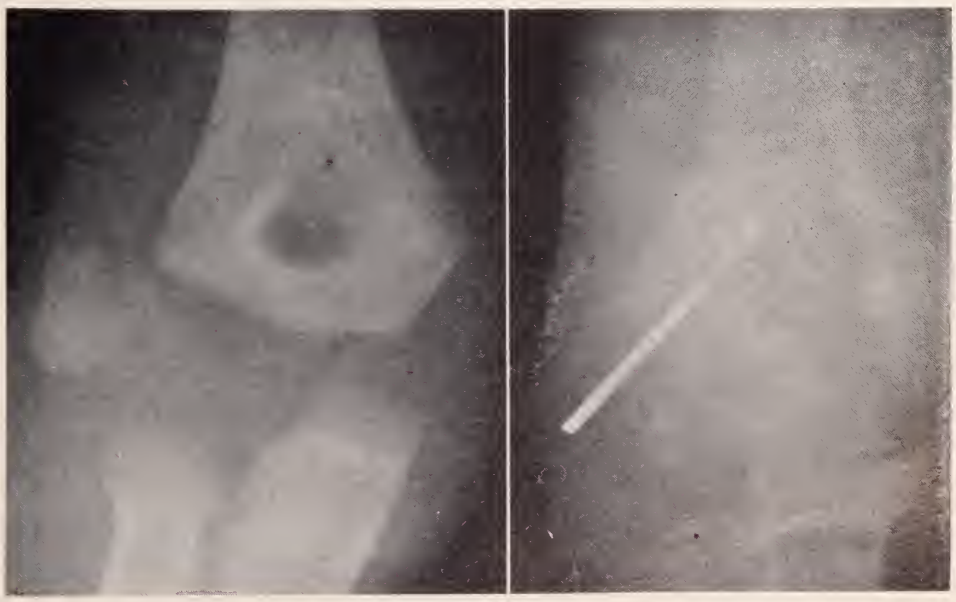


Fig. 10.—The roentgenograms of the elbow of a six year old boy show a fracture of the lateral condyle of the elbow with marked displacement. A fracture involving the epiphyseal plate and the articular surface should be repositioned anatomically if possible. In this case this was best accomplished by an open reduction. A Kirschner wire was used as internal fixation and removed after three weeks (b). A small smooth pin crossing the epiphyseal plate for a short period of time will not retard growth.



a. Original roentgenogram.



b. Three months following the fracture.



c. Two years following the fracture.

Fig 11.—In a 13 year old girl there was a fracture of the neck of the radius with a complete separation and displacement of the head of the radius. An attempt at a closed reduction failed. The position of the fragment was improved by performing an open reduction. No internal fixation was used and there was a slight persistent displacement. Roentgenograms taken two years after the injury show only a slight deformity. A clinical examination showed no limitation of motion other than a loss of 20 degrees of supination. In a child joint fragments of large size such as the head of the radius should not be excised.

More angulation and displacement can be accepted in children than in adults. The spontaneous correction with growth of the long bone is greatest in very young children when the fracture is near the end of the long bone.

Growth retardation or arrest may occur if that portion of the epiphyseal plate responsible for growth is injured.

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Laryngeal Manifestations of Allergy

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Manifestations of allergy are just as prone to occur in the larynx as elsewhere in the body. Usually, they are associated with some nasal manifestation of allergy; however, they can be present without any indication of nasal allergy, or allergy elsewhere in the body. When present with nasal allergy, usually the distressing features of the nasal allergy so dominate that laryngeal factors are frequently overlooked.

Laryngeal allergy in its early stages is frequently confused with some mild upper respiratory infection, or incipient laryngitis. The major complaint of many of the patients is some hoarseness, or vocal weakness in that their voices tire easily on prolonged usage. There may be a concomitant postnasal drip, and frequently there is a sensation of fullness in the throat, or a feeling of some type of growth being present, or the inability to clear the throat fully.

Diagnosis is dependent upon features that are common to all cases of allergy, namely, detailed history, nasal and bronchial cytology, appropriate skin testing when indicated, and the clinical appearance of the lesions.

The initial evaluation of these patients should be an extremely thorough one, for by far the greater portion of them consult the otolaryngologist fearing that they have some laryngeal malignant disease. A superficial evaluation without a thorough examination of the larynx by direct or indirect laryngoscopy will do little to allay this apprehension. The nasopharynx should be carefully evaluated in all of these patients, as cysts, edema, polyps, or malignant disease can be present in this area and frequently will produce a globus syndrome. Any of these will cause persistent symptoms even after other appropriate therapy has been instituted. In many, laboratory procedures such as the protein-bound iodine test for determination of the basal metabolic rate, barium swallow, fluoroscopy, and roentgenograms of the chest may be desirable; they should be ordered at the time of the first visit, and the reasons for performing these tests should be told the patient.

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The clinician should realize that allergy of the respiratory tract rarely exists alone, but any allergic phenomenon which may be acute in onset may be immediately or coincidentally complicated by infection. In other words, it is well established that allergy predisposes to and aggravates many diseases of the respiratory tract. By the same token, infectious diseases may precipitate an allergic phenomenon to which the patient had previously acquired some degree of immunity. This, in turn, accounts in my practice for the great numbers who come into the office complaining of persistent cough or hoarseness, following episodes of upper respiratory infection in which the respiratory or acute infectious phase had been controlled. The underlying mechanism of infection had triggered a dormant or subclinical allergic tendency, which can be adequately controlled by allergic management. In allergic persons who are susceptible to reactions in the mouth, tongue, pharynx and larynx, transitory attacks of edema may occur that are so mild that alarming symptoms never occur. These transitory swellings of the pharynx may account for many cases of so-called pharyngeal neurosis or globus hystericus.

Common Causative Factors

Agents that are most frequently indicated as producing edema of the larynx are: (1) administration of antitoxin; (2) some antibiotics; (3) iodides; and (4) acetylsalicylic acid. A recent case of anaphylactoid death after usage of a commonly prescribed throat lozenge consisting of benzocaine, tyrothricin and chlorophyl has been reported. With the widespread use of antibiotics and sulfonamides, reactions resembling serum sickness have become common; although some reactions might be severe, they are usually not dangerous unless the larynx becomes involved. Cases of laryngeal edema following administration of penicillin orally and by injection have been recorded. Some of these reactions may be immediate; however, delayed reactions occurring four days to a week subsequently are not unusual.

Among the drug factors producing laryngeal edema, coal tar products such as acetylsalicylic

acid and similar preparations are most commonly encountered as etiologic agents. The inhalant factors producing laryngeal edema are usually animal danders, house dust and cosmetics.

Laryngeal paralysis following the injection of tetanus antitoxin has been recorded. This type of difficulty is usually a late reaction occurring about eight days following the administration of antitoxin, and, as a rule, the paralysis will gradually clear up in a period of about six weeks to six months. Paralysis of other cranial nerves may occur following administration of antitoxin and may occur during serum sickness reaction.

Acute Laryngeal Edema

There are few conditions that require more prompt diagnosis and treatment if the life of the patient is to be saved than that of acute edema of the larynx. Acute attacks may come on at night after the patient has retired; and it is possible that many remote and obscure deaths occurring in the middle of the night may be of this nature. Examination of the larynx, in cases of obscure death, should be mandatory on autopsy.

The onset of edema of the larynx may occur so rapidly that treatment must be administered immediately to prevent death. This treatment consists of injections of epinephrine, intravenous cortisone, oxygen, and tracheotomy in the foregoing sequence or simultaneously.

In the management of all types of allergy, the role of tobacco should be given serious consideration. Tobacco may act as a primary irritant, or a secondary irritant in an allergic person. All who have indications of laryngeal allergy should abstain from smoking.

The basic allergic pathologic condition encountered is tissue edema, occasional eosinophilic infiltration and seromucinous discharge of glandular origin. The edema may be transitory and disappear with removal of the allergic agent. When allergic irritation persists, edema may become more pronounced, and polypoid changes may ensue. These polypoid changes may be of such a degree as to produce respiratory obstruction. Case presentations which follow illustrate these varying degrees of pathologic change.

Report of Cases

Case 1.—A white, married woman, aged 42, was first seen in October 1950, complaining of hoarseness of one year's duration. She had previously been seen elsewhere and was considering having a laryngeal operation performed. The laryngologist who had seen her recommended that she have a suspension laryngoscopy and an intralaryngeal dissection of redundant mucous membrane of her vocal cords. When seen at that time there was cystic-like swelling of the left and right vocal cords. The glottis was a slitlike space. I advised the patient that surgical therapy was to be considered; however, her nasal cytologic examination showed an abundance of eosinophils, and allergic investigation was advised as concomitant treatment so as to prevent recurrence. Surgical measures were to be deferred for a short period of time so as to permit an adequate allergic investigation. She proved to be markedly sensitive to smoke, dust, and atmospheric molds. Therapy was begun on November 8, and on November 13 it was noted that the cords were improving; on November 17 edema of the cord was receding, and on November 22 the vocal cords were normal in appearance. On November 29 the patient had an upper respiratory infection, and there was a temporary exacerbation of edema of the left vocal cord. Antibiotics were prescribed. On December 11, the larynx was clearing, and by Jan. 17, 1951, the larynx was completely normal in appearance. The patient was not seen again until Jan. 7, 1953, at which time she gave a history of just getting over influenza and having taken courses of penicillin, Chloromycetin, and sulfonamides prescribed by her family physician, and she was very hoarse. Indirect laryngoscopy showed a large polyp of the left vocal cord with some keratosis. Desensitization was begun, and on January 19, it was noted that the keratosis had disappeared and the polyp on the vocal cord was receding. By February 2 the cords were again normal in appearance. The patient was subsequently seen in February 1956, at which time there was a small polyp on the midportion of the left vocal cord, incidental to upper respiratory infection. She had started using tobacco again. Antiallergic management in conjunction with antibiotics was begun and she was advised to avoid tobacco. In two weeks' time the polyp had completely receded. She was seen in March 1960 with upper respiratory infection, but the cords at that time were normal in appearance.

Case 2.—A white woman, aged 47, complained chiefly of hoarseness for many years which seemed to have become worse of late; she often had spells of choking and dyspnea. She was informed by her family physician that it was merely her nerves that caused her difficulty. Indirect laryngoscopy revealed marked polypoid hyperplasia of both vocal cords, partially occluding the glottis. The respiratory difficulty was so marked that it was deemed advisable to perform an operation immediately so as to have an adequate airway available. On direct laryngoscopy at the time of the operation, the superior surface of the left vocal cord was stripped of its markedly edematous hyperplastic mucosa. The under surface of the left vocal cord revealed a large polypoid growth that hung into the trachea below. Undoubtedly, the intermittent episodes of dyspnea occurred when this polypoid growth inadvertently occluded the narrowed glottic chink. The right vocal cord was not disturbed at the time of the operation for fear of causing scar tissue and web formation. The patient was subsequently followed in the office. Skin testing revealed a markedly positive reaction to smoke, dust, and atmospheric molds. She has undergone desensitization, and the hyperplasia of the right vocal cord has disappeared. She was seen at the office one month ago and was asymptomatic.

Comment

The foregoing cases represent marked degrees of an allergic pathologic condition of the larynx. For these few there are innumerable cases of transitory edema of the larynx producing hoarseness or globus, which unless accurately evaluated produces pharyngeal or laryngeal neurosis. Many persons with this condition go through their entire life with their ailment improperly diagnosed and are referred to a psychiatrist for therapy. Most

of them do not require prolonged allergic management unless the difficulty persists.

Summary

Laryngeal allergy is of frequent occurrence, but is usually accompanied by other allergic manifestations that overshadow its presence. When it is acute in nature, intensive therapy must be instituted if life is to be saved. In all cases of obscure death, and especially when it occurs after the patient has retired, the larynx should be examined at autopsy.

Many of the patients with laryngeal allergy, because of their bizarre complaints, are relegated to the category of globus hystericus. Those who have this difficulty on the basis of an underlying allergy respond very satisfactorily to allergic management.

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Death Following Penicillin Injection

Report of Three Cases

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In 1947, Kendig and Toone[1] wrote: "Anaphylactic sensitization to penicillin can occur and patients subjected to second courses of treatment with the drug should be observed with added caution. Promiscuous use of penicillin in trivial infections should be avoided because of this feature." Today, 13 years later, the warning of the second sentence is still applicable, the more so since a greater amount of penicillin is being used on a larger population. Of this larger population, 5 to 10 per cent are becoming allergic to the drug in one way or another.[2] Penicillin remains the major cause of fatal anaphylactic reactions.[3]

In December 1959, we reported three fatal anaphylactic reactions caused by penicillin.[4] We can now add two more similar cases to this series. These have occurred with a three month period.

Report of Cases

Case 1.—A 57 year old white housewife was seen in a doctor's office for cystitis. The doctor had previously given the patient penicillin, the last occasion being 10 months before the fatal episode. At no time did she exhibit any sign of allergy. Accordingly, the physician injected 600,000 units of aqueous procaine penicillin into the right gluteal muscle. Shortly thereafter, the patient remarked that she could taste the penicillin in her mouth. Approximately five minutes later, she complained of dyspnea. She became cyanotic and slumped down in the chair. The doctor administered adrenalin and Neutrapen, performed a tracheotomy, and gave artificial respiration to no avail. The patient was pronounced dead 20 minutes after the penicillin injection.

Autopsy was unremarkable except for angioneurotic edema of the false and true vocal cords. Penicillin was found within the gluteus medius muscle of the right buttock with no evidence of large blood vessel penetration.

Case 2.—A 32 year old Negro man consulted an osteopathic physician for treatment of gonorrhea. Four months earlier, he had been seen by the same physician for an earache and had been given penicillin with no ill effects. On the present occasion, the patient was given 600,000 units of procaine penicillin into the deltoid muscle. He collapsed on the examining table, foamed at the mouth, and expired, one and a half minutes having elapsed between the time of injection and the time of expiration.

The chief pathological features of the autopsy were pulmonary congestion and a moderate increase of relatively nonviscid mucus in the bronchi.

Since the occurrence of these two cases, an additional sudden death following parenteral administration of pencillin has come to our attention. This third case, however, is complicated by the presence of a natural disease process which has been given precedence as the direct cause of death. It is presented here to demonstrate the

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problems met in interpreting the clinical and autopsy findings surrounding a presumed allergic death.

Case 3.—A 13 year old white boy was known to have a severe congenital heart defect with a guarded prognosis. About 11 months previously; he had received penicillin and had shown no signs of allergy. In fact, his physician stated to an interviewer that in the last six years, the patient had been given more than 25 injections of penicillin with no ill effects. At the time of the fatal episode, the boy was given 300,000 units of procaine G penicillin because of an earache. Leaving the doctor's office, the patient walked approximately a block and a half when he collapsed. He was returned to the doctor's office where, despite the administration of oxygen and intracardiac adrenalin, he failed to respond and was pronounced dead. Approximately one hour and 20 minutes had elapsed between the time of injection and the pronouncement.

The autopsy revealed atrial and ventricular septal defects, pulmonary artery dilatation, a patent ductus arteriosus, and bilateral myocardial hypertrophy. The lungs were congested and partially atelectatic. The larynx was not edematous. No evidence of an intravascular penicillin injection was found.

Generally, the clinical diagnosis of a sensitivity reaction to penicillin is made in a negative fashion based on the coincidental relationship of injection to reaction. This diagnosis is strengthened by the characteristic lack of outstanding autopsy findings of natural disease. In addition, a positive clue such as angioneurotic edema may be present. Demonstration of antibodies to penicillin in the serum is another positive clue.

Although the time lag in this case between the injection and death was one hour and 20 minutes, such delayed reactions have been reported[5] in cases of fatal sensitivity reactions. The presence, however, of severe congenital heart disease with a short life expectancy precludes the diagnosis of a sensitivity death.

Discussion

In spite of occasional warnings appearing in the literature today on the injudicious, almost reckless, use of the drug, fatal anaphylactic reactions caused by penicillin are becoming increasingly frequent. Penicillin, in sensitizing dose form, is all about us. Sometimes, it remains in syringes with which penicillin has been previously administered; sometimes, it is in the milk from cows treated for bovine mastitis, a disease affecting an estimated 25 per cent of the cows in the United States; it generally is found in at least two types of vaccines on the market today. It certainly is found in the treatment some physicians use for the common cold, slight fevers of unknown origin, and minor skin infections which they or their patients euphemistically hope a "shot of penicillin" will cure. There is at least one case on record where the medication has been used in the treatment of epidemic parotitis.[6]

As stated in our previous article, the physician should weigh most carefully the indications for the drug against the potential risks involved. He should not allow himself to be pressured by the patient into administering penicillin, but, like the umpire, he should "call it as he sees it." If there is a definite indication, if no other safer medication will do the work, if the physician would honestly want the penicillin injected into himself under similar circumstances, the patient should receive the medication. If, however, the indication for penicillin is hazy and/or, according to the patient's history, the risk is great, penicillin should be avoided.

The physician should inquire thoroughly into the patient's history. Had the patient received a number of previous injections of penicillin in the past? Had there been any reactions? Had the patient had any manifestations of allergy and if so, to what? One of the widely advocated tests —skin-scratch, conjunctival, or "tongue"—should be made routinely if more than two weeks have elapsed between injections. In this day when high concentrations can be obtained in small amounts of fluid (600,000 units per cubic centimeter), the injection site should be moved from the buttocks to the arm so that when seconds may be life-saving, a tourniquet can be placed quickly and easily about the arm proximal to the site. In addition, the chief defense against anaphylactic reactions—aqueous epinephrine, 1:1000—should be kept handy, "just in case."

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Tuberculin Testing in the Schools of Palm Beach County

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In 1955 following a review of the tuberculosis problem in Palm Beach County, we decided to explore the possibility of extending our use of the tuberculin test among school children of our county. The purpose of such testing would be:

1. To learn more about the geographic distribution of tuberculosis in Palm Beach County.
2. To find tuberculosis among adults and children through follow-up of reactors and their contacts.
3. To stimulate education of people throughout the community with regard to tuberculosis.

To plan the details of this program a meeting was held with representatives of the following agencies:

Florida State Board of Health, Bureau of Tuberculosis Control
Palm Beach County Tuberculosis and Health Association
Palm Beach County Medical Society
Southeast Florida Tuberculosis Hospital
Palm Beach County Health Department

The committee recommended that a tuberculin testing program be started in schools of Palm Beach County during the 1955-1956 school year but that the testing be confined to children of kindergarten and first grade during the first year. In addition, it was recommended that the total school population be tested in several schools in various parts of the county, in order to obtain additional information regarding the prevalence of tuberculosis. The committee agreed to meet again at the end of the first year of testing in order to evaluate the results and to make further plans.

Financing the testing program was a problem in view of the fact that funds for this purpose had not been provided in the Health Department budget. The Palm Beach County Tuberculosis and Health Association came to the rescue with money to pay for additional physician and nursing time, and for the necessary records and forms. The Tuberculosis Association also furnished educational materials and volunteer assistance.

Before starting the testing, approval and active support of the program were obtained from the Palm Beach County Medical Society. A practicing physician volunteered his services on a part time basis. A registered nurse was employed, also on a part time basis.

Approval of the County Board of Public Instruction and Superintendent of Schools was obtained. The program was explained to principals, teachers, Parent-Teacher Associations, and students. We were surprised to find how little was known about this test and its value. The great number of questions raised afforded additional opportunities for education.

Following the first year of testing, the Planning Committee met again and agreed that the program had achieved the objectives of case finding, education, and obtaining information concerning prevalence, in so far as would be expected in one year. The committee recommended continuing the testing with certain modifications, such as adding second grade students. Annual meetings have been held since 1955, and the program has been continued each year with changes. At the last meeting in 1959 addition of ninth and twelfth grade students was recommended.

Methods

There was unanimous agreement that intradermal (Mantoux) tests would be used with intermediate strength tuberculin (0.0001 mg. P.P.D.). During the first and second years of testing, 1955-1956 and 1956-1957, it was decided to call induration over 5 mm. in diameter positive. In subsequent years, the advice of Dr. Carroll Palmer was followed, and induration 0-4 mm. in diameter was called negative, 5-9 mm. doubtful, and 10 mm. or more positive.

Prior to testing in a school the program was discussed with principals, teachers, health co-

Table 1.—Percentages of Tuberculin Reactors Among White and Negro Children of Kindergarten, First and Second Grades Palm Beach County 1955–1959

School Year	Enrollment (Kindergarten, First and Second Grades, except 1955-1956)	Number of Tests Read	Percentage of Tests Read	Number of Tests Positive (10 mm. and above)	Percentage of Tests Positive (10 mm. and above)
1955–1956					
White	2,616	1,921	73.4	8	0.4
Negro	1,366	855	62.6	9	1.1
Total (Kindergarten and First Grade)	3,982	2,776	69.4	17	0.6
1956–1957					
White	5,601	3,894	69.4	32	0.8
Negro	2,670	1,399	52.1	32	2.3
Total	8,271	5,293	63.8	64	1.2
1957–1958					
White	6,139	4,155	67.7	28	0.6
Negro	2,826	1,490	52.7	50	3.3
Total	8,965	5,645	63.0	78	1.4
1958–1959					
White	6,620	5,064	76.5	31	0.6
Negro	3,305	2,390	72.3	113	4.7
Total	9,925	7,454	75.0	144	1.9
Total White	20,976	15,034	71.8	99	0.6
Total Negro	10,167	6,134	59.9	204	2.9
Totals: 1955—1959	31,143	21,168	67.8	303	1.3

Table 2.—Follow-Up of Tuberculin Reactors Among Kindergarten, First and Second Grade Students, and Students of Four Total Schools Palm Beach County, 1955–1959

	1955–1956 (5 mm. +)	1956–1957 (5 mm. +)	1957–1958 (10 mm. +)	1958–1959 (10 mm. +)	1955–1959 Totals
Number of reactors	202	225	71	272	770
Number x-rayed	161	164	67	254	646
Per cent x-rayed	80%	73%	94%	93%	Ave: 85%
Reactor cases	0	0	7	3	10
Adult contacts	499	550	110	571	1,730
Number x-rayed	297	423	74	405	1,199
Per cent x-rayed	60%	77%	67%	71%	Ave: 69%
Adult contact cases	6	5	5	3	19
Child contacts	425	509	148	761	1,843
Number tuberculin tested	360	438	107	701	1,606
Per cent tuberculin tested	85%	86%	72%	92%	Ave: 84%
Number tuberculin positive	67	64	20	114	265
Per cent tuberculin positive	19%	15%	19%	16%	Ave: 17%
Number positive x-rayed	44	41	14	102	201
Per cent positive x-rayed	66%	64%	70%	89%	Ave: 72%
Child contact cases	2	0	2	0	4
Total cases found	8	5	14	6	33

ordinators, and parents. Cooperation of Parent-Teacher Associations was obtained in selling parents on the plan and providing volunteer assistance. The National Tuberculosis Association publication "Tuberculin Tests for Your Pupils" was very helpful in explaining the program to teachers, and a leaflet "The Tuberculin Test" was sent to parents with the form requesting the tuberculin test. Explanatory letters were also sent with the request forms. When these forms were returned, schedules for testing were arranged, taking into consideration the best time for school administrators, nurses, and physicians.

The committee decided at the beginning of this program that the same nurse would administer all tests for the sake of uniformity. We preferred to have all tests read by a physician, and this was done 48 to 72 hours after the tuberculin was injected. Most of our testing has been done with platinum needles which are flamed after each test. These needles expedite the testing procedure and save time required for sterilization.

Test results were recorded on a special card which provided for individual data on the child tested, and on the reverse side provided for data on contacts of reactors. This record gave the name, date of birth, address and school of the child tested. It also gave the sex, race, age, grade, date of test, test results (including diameter of induration in millimeters), date of x-ray and other information. For reactors, names of contacts were given with the relationship, age, and type of association. For the contacts, the date and results of tuberculin tests and x-rays were recorded. Because of the large amount of time required for recording all these data, after two years in which complete information was kept on negative as well as positive reactors, the committee recommended keeping these special records only on reactors.

As soon as possible after tests were read, letters were sent to parents giving them the results of the tests. During the first year of this program we found that letters reporting positive and doubtful results caused unnecessary apprehension among parents receiving these letters. For some reason the doubtful report caused more concern than the positive and so was discontinued. Instead, the public health nurses began making telephone contacts or home visits to parents of positive and doubtful reactors, explaining the significance of the test and the follow-up indicated. Of course all follow-up measures were carried out with the understanding and approval of the family physician, and in many cases the private physician assumed responsibility for follow-up.

Follow-up included taking x-rays on all positive reactors and adult household and other close contacts. Child contacts were tuberculin-tested, and positive reactors were x-rayed. Doubtful reactors among students and their contacts were retested in three months and if they continued to be doubtful, or were found to be negative, no further follow-up was done. All persons showing x-ray evidence of tuberculosis were referred to their private physician or to the Health Department Chest Clinic for diagnosis and indicated treatment.

Results

Over the four year period 1955-1959 a total of 21,168 tuberculin tests were read among children of kindergarten, first and second grades. Of these, 15,034 were white, and 6,134 were Negro. The actual number of tests made was somewhat more than this, but absenteeism brought the total number read down to an average of 67.8 per cent of the total enrollment in the grades tested. The percentage of tests read among white children was consistently higher than that among Negro children, although in the last year reported the percentage for both was above 70 per cent, and the average 75 per cent.

Table 1 shows results of tests for the four year period. Although reactions above 5 mm. induration had been called positive during the first two years of testing, figures in this table have been corrected so that only those reactions 10 mm. and above are reported as positive. This is done so that comparisons can be made between results for different years. Positive reactors from the previous year are included in the analyses so that percentages reflect all positive reactors in the groups tested.

During the first year of testing only kindergarten and first grade children were included, except for the total schools tested which are not reported in this table. This limitation largely accounts for the fact that the percentage of positive tests during 1955-1956 was considerably lower than in later years. Comparison of percentage of positive reactors for the four years covered in this report shows a progressive increase in the number and percentage of positive reactors among Negro children which is reflected in total increases. No comparable change was observed in the percentage of white reactors. A large propor-

Table 3. — Tuberculin Reactors in Total School Population of Representative White and Negro Schools of Palm Beach County

	Seacrest (White High School)	North Grade (White Grade School)	Pleasant City (Negro Grade School)	Lake Shore (Negro Grade and High School)	Totals
Number read	420	55	76	1,016	1,567
Number positive	26	3	9	196	234
Per cent positive	6.2%	5.5%	11.8%	19.3%	Ave: 10.7%

tion of the positive reactors among Negro children was found in the western part of the county. This is the farming area where many migratory agricultural laborers live and the population fluctuates more than in other areas, with many new persons present during the winter months when most of the testing was done.

Table 2 shows the follow-up of all positive tuberculin reactors obtained during the four year period. Because induration of 5 mm. and over was called positive during the first two years of this study, follow-up was done on all such reactors and these are included in the table. Also included are reactors obtained by testing all grades in four schools. This will explain some of the apparent discrepancies in the figures for the number of reactors followed.

The total number of reactors receiving follow-up during the four year period was 770. Of these 646 were x-rayed, an average of 85 per cent. Adult contacts of reactors who received follow-up totaled 1,730, but we were able to obtain x-rays on only 69 per cent of these or 1,199. Of the 1,843 child contacts followed, 1,606 received tuberculin tests. In 265 of those tested the reaction was positive, which was an average of 17 per cent. X-rays were obtained on 201 of the positive reactors.

A total of 33 cases of tuberculosis was found during this four year survey. Ten of these were among the positive reactors, 19 were among the adult contacts, and four were among the child contacts. Twenty-seven of the 33 cases were among Negroes, and six were among white persons. Fifteen of the 19 adult cases were previously known to the Health Department, but only three of the 14 primary cases found among children were previously known.

One interesting observation was the relationship between the size of tuberculin reaction of the index child and cases of tuberculosis found. The diameter of induration was 10 mm. or more in students who were found to have tuberculosis, or where tuberculosis was found among their contacts, in all except two children, during the two years in which reactions of 5 mm. or more were called positive. Less than 15 per cent of reactors in the five to nine year age group were found to have induration 10 mm. or more in diameter.

Table 3 shows the results of tests made on total school populations in various parts of the county. White and Negro elementary and high schools are represented. As would be expected, the Negro schools showed a much higher percentage of reactors than the white schools, an average of 15.6 per cent Negro students compared with 5.9 per cent for white students. Lake Shore School (Negro) showed a particularly high rate of positive reactors, 19.3 per cent for grade and high school. The percentage for the Lake Shore Grade School was 15.4 per cent whereas the High School showed 25.2 per cent reactors. This school is in the agricultural area of Palm Beach County which has many migratory laborers during the winter months. There are also many residents in the lower socioeconomic groups in this area.

Particular attention has been given to children who converted from a negative to positive tuberculin reaction. A study was made of 32 children six and seven years of age who converted between first and second grade testing. None of the x-rays obtained on these children showed significant abnormalities. Sixty-nine child contacts who were tuberculin-tested showed five positive and three doubtful reactions. Among 69 adult contacts x-rayed, in 67 the evidence was negative, one new moderately advanced case of tuberculosis was found, and there was one old case.

Discussion

Tuberculin testing has been advocated among school children as a method of case finding (primarily among adult contacts) for determining the

prevalence of tuberculosis, and to identify reactors, especially converters, among children. Education of the general public, parents, teachers, children, and professional groups is an important benefit derived from this program.

The youngest school children were primarily selected for this study because the range of contacts would be more limited, infection in positive reactors would have occurred more recently, and, hopefully, the source of infection would be found among household contacts.

Actually, as a case-finding tool in our experience, the yield of new tuberculosis among adult contacts of children tested was rather disappointing. We did not duplicate the results of Wood, Furcolow and Willis in Kansas City where about 12 times as many new cases were found as had been obtained by mass x-ray survey. We found more previously unknown cases of primary tuberculosis among reactors and their child contacts. Follow-up on a large proportion of contacts, however, could not be completed because they occurred among the mobile population which goes north in the spring. This group would be expected to yield a larger number of active cases among the contacts.

A finding difficult to explain is the increase in the percentage of positive reactors among the Negro students tested. Some of this may be attributed to the fact that increased effort was exerted in successive years to reach that part of the population which is less cooperative or less informed. This is also the part which may be expected to have a larger share of the tuberculosis.

During the four year period of testing there was certainly no decline in percentage of positive reactors, even among white children tested. The period of time involved, however, was not sufficiently long to establish trends. The average percentage of Negro reactors was somewhat higher than the percentage obtained by Wood, Furcolow, and Willis in Kansas City (2.9 per cent compared with 2.6 per cent). On the other hand, the percentage of white reactors in our study was somewhat lower (0.6 per cent compared with 1.5 per cent). The tuberculosis death rate in Palm Beach County is declining, but the number of active cases under supervision has not declined proportionately.

As a measure of the prevalence of tuberculosis, we have found this testing to be helpful. Previous mass x-ray surveys had given us some information regarding the geographic distribution of cases, but we know that people living in areas with the highest prevalence often are those least willing to get an x-ray during a mass survey. Some of this same reluctance or negligence certainly affects the extent of participation in tuberculin testing programs, but many families are reached in this way who would probably not be contacted in an ordinary x-ray survey.

The identification of tuberculin reactors among school children has great importance in so far as future incidence of active tuberculosis is concerned. Follow-up of these children and their contacts will help to guide our future efforts in tuberculosis control.

One of the benefits of this program which is difficult to measure directly is the stimulation of education with reference to tuberculosis. This started with a review of our tuberculosis problem by members of the Health Department, Medical Society, and Tuberculosis Association. Appreciation for the tuberculin test as a potent weapon in tuberculosis control was developed. Later, teachers, parents, and students were involved as active participants. Many questions were raised, not only concerning the tuberculin test, but also regarding tuberculosis in general, its method of spread, diagnosis, and treatment. The general public was informed through talks, newspaper articles, radio, and television. Perhaps the educational benefits will be the greatest reward for this effort.

A great deal of planning and follow-up is involved in a tuberculin testing program. The most critical item in all of this is public health nursing time required for follow-up of reactors and their contacts. Much time and thought must be given to proper records, and careful evaluation is necessary. This sort of program should not be undertaken without thorough planning, or without adequate staff and facilities for testing and follow-up.

Summary

Results of the first four years of a tuberculin testing program among school children of kindergarten, first and second grades are presented. Results of testing children in four total schools are also given. The number and percentage of positive tests are given by year for white and Negro students. Results of follow-up among child and adult contacts are discussed.

The following observations were made:

1. Tuberculin testing gives a more complete

picture of the prevalence of tuberculosis than can be obtained in other ways.

2. There was a greater difference between the percentage of white and Negro reactors than we had thought prior to the study.

3. There was no apparent decline in the percentage of reactors during the four year period. On the contrary, there was an increase in the percentage of Negro reactors, attributed to greater efforts made to test lower socioeconomic groups, and the mobile population in this area.

4. The number of new primary cases of tuberculosis found among reactors and their child contacts was larger than the number of new cases found among adult contacts. Most of the tuberculosis among adult contacts was already known.

5. There was a direct relationship between size of the tuberculin reaction and the number of contacts with active tuberculosis.

6. Follow-up of converters did not produce significantly more tuberculosis than follow-up of children who were positive reactors on the first test.

7. Educational benefits were among the most important derived from this program.

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Modification of Plasma Lipoproteins by Estrogen in Elderly Males

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Atherosclerosis is an extremely common disease in this country in both adult men and women. The extent of the disorder tends to be somewhat greater and appears at a younger age in men. We would expect that the incidence of coronary heart disease would parallel that of atherosclerosis in both sexes; however, it has been estimated that clinical coronary heart disease occurs about 10 times more often in the male. Under the age of 40, during the premenopausal period of women, the male has the unfavorable odds of approximately 25 to 1, but this difference decreases rapidly in postmenopausal years.[1-6] It has been considered that a greater thickness of the arterial intima may be one factor accounting for the increased incidence of clinical coronary disease in the male.[7] It is interesting to note that although the concentration of total lipids, cholesterol, and phospholipid has been found to be approximately equal in males and females, there are obvious differences in the fat composition of the plasma in men and women, which may be demonstrated by chemical fractionation of the plasma electrophoresis, and by use of the ultracentrifuge.[8, 9] Men in the age group below 40 have a significantly larger amount of their total blood lipid in the form of beta lipoprotein and a correspondingly smaller amount as alpha lipoprotein. The premenopausal female has a higher concentration of blood lipid as alpha lipoprotein with a relatively lower beta lipoprotein. After the menopause the female pattern changes toward that of the male with an increased beta lipoprotein and a decreasing alpha lipoprotein. In this respect there is conformity of results from chemical fractionation, ultracentrifugation, and electrophoresis. Pick, Stamler, Rodbard and Katz[10] demonstrated that the administration of estrogen in chickens inhibits the development of coronary atherosclerosis, and that estrogen therapy causes a regression of coronary atheroma, although the degree of aortic atherosclerosis is not significantly

modified. In man it has been demonstrated that estrogen administration can change the lipid pattern usually seen with advanced coronary disease to one that cannot be distinguished from that of premenopausal women.[3]

Analysis of Series

In this study, 20 male patients between the ages of 65 and 85 were studied by means of serum electrophoresis before, after and during administration of daily doses of estrogen. All patients were ambulatory and had clinical and laboratory evidence of atherosclerosis.

Paper electrophoretic patterns were obtained on both serum protein and serum lipoproteins by electrophoretic method,* as follows:

Moistened strips were arranged on a hinged rack in an inverted "V". A sample of serum was applied to each strip at the top of the inverted "V" and separated in an electric field provided by a regulated power supply. When separation was complete, the strips were oven-dried and stained with bromophenol blue in dilute acetic acid. After staining, the strips were scanned with an automatic recording photometer which plotted the relative concentration of material along the strip.

Second sets of paper strips were then set up using larger quantities of serum, and separated for the same period of time and voltage. These strips were stained in saturated alcoholic solution of oil red O for 15 to 18 hours, air-dried, then placed in the automatic recording photometer with the tracing superimposed on the original serum protein tracing for proper identification of lipoprotein fraction. Due to the differences in staining techniques and resulting in changes in base lines for tracing and amounts of samples used, no quantitative results were obtained.

Before administration of estrogen, each of the 20 male patients was found by this technique to have the usual atherogenic pattern with large beta lipoprotein fractions. Each patient was then given estrogen as Premarin, from 5 to 10 mg. daily, depending on tolerance, for approximately four weeks. Additional electrophoretic determinations of serum protein and lipoprotein were made during and after estrogen administration. On this relatively small dosage of estrogen over a three to four week period, each patient demonstrated significant changes in serum lipoprotein patterns toward the pattern of the premenopausal female, that is, a decrease in beta lipoprotein and increase in alpha lipoprotein. There was a return toward the original pattern of predominant beta lipoprotein in patients checked approximately two weeks after cessation of therapy.

In three patients not included in this study it was thought necessary to discontinue estrogen administration because of undesirable side effects, consisting of malaise and nausea in two patients and an emotional disturbance in a third. Of the 20 patients who completed the study, 13 complained of no side effect and believed that they felt as well as before therapy. Seven patients noted some nipple soreness with slight gynecomastia, which persisted in one case for four weeks after cessation of therapy. Two patients complained of sluggishness and moderate headache. A semiretired physician, age 85, noted a paradoxical increase in libido with appearance of nocturnal emissions, which he had not experienced for over 20 years. He also noted moderate increase in lower urinary tract obstruction, presumably of prostatic origin, which subsided within a few days after discontinuing estrogen. Libido was unaffected or slightly decreased in other patients, but was not considered an important factor because of the age group (65-85).

Summary

Administration of relatively small amounts of estrogen over periods of approximately four weeks significantly altered serum lipoprotein patterns in elderly male patients. This alteration was away from the atherogenic pattern and toward the premenopausal female pattern consisting of a more prominent alpha and a lower beta lipoprotein fraction. The incidence of side effects was relatively small. The major complaint, loss of libido and lethargy, noted in younger patients, was minimal in patients of this older age group.

It is problematical as to whether or not longer periods of administration of estrogen with its demonstrable effect on blood lipids might improve the status of atherosclerosis in elderly male patients with clinical evidence of this disease. It is probable that much wishful thinking accompanies most attempts to reverse atherosclerosis in the aged, whether by diet, cholesterol inhibiting agents, or agents that modify the blood fat composition. Nevertheless, it is desirable that all possible avenues of treatment, including estrogen therapy, be carefully evaluated before being either embraced or discarded.

*Spinco Model R paper electrophoretic apparatus.

The estrogen used in this stury was supplied as Premarin through Dr. John B. Jewell of the Ayerst Laboratories, New York, N. Y.

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The Nose and Pregnancy

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Nasal congestion, obstruction, hyperemia, hypersecretion, epistaxis and sneezing spells may occur during pregnancy. Transient blockage of the airway to a constant, intense engorgement with headaches and fullness of the ears may also be present. These symptoms usually do not disappear until the termination of the pregnancy, or shortly thereafter. The nasal membranes are not like those presenting an allergic manifestation, but the appearance is that of an infective rhinitis. Although the nasal process is not a serious one, it can be annoying to an already uncomfortable pregnant woman.

The relation of the nasal mucosa to ovarian function is well known and is evidenced by the mucosal changes observed during pregnancy. The reflex action existing between the various erectile tissues of the nose and that of the reproductive system is adequately exemplified by the synchronous physiological association. The nasal mucosa in some pregnant women becomes highly hyperemic and swollen. Bleeding areas are not uncommon. Polyposis tends to recur with each succeeding pregnancy. Some patients may have suffered from hay fever or other allergic affections in the past, but in the majority, nasal smears do not reveal an abnormal number of eosinophils. In view of the absence of allergic symptoms, the nasal process is not believed to be typical of an antigen-antibody mechanism. Although the precise relationship between the nasal nerves and the reproductive system is not known, it has been theorized that the sphenopalatine ganglion may influence the function of the latter.

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Sensory disturbances of the nose are demonstrated by abnormal responses of the olfactory and trigeminal (first and second division) nerves. These represent the afferent pathways in the nasal cavity. The absence of striated muscle within the nasal cavity confines all motor functions to the autonomic nervous system. Neurons of the autonomic system are distributed within the nasal mucosa from the superior cervical sympathetic ganglions and from the sphenopalatine ganglions. The superior cervical sympathetic ganglions represent the sympathetic system while the sphenopalatine ganglions represent the parasympathetic system. Their functions are antagonistic individually, but when acting in unison, they are complementary. When the sympathetic system is stimulated, a dry, irritable mucosa is produced with vasoconstriction. The parasympathetic system, on the other hand, produces increased supply of mucus and vasodilation. In allergic disorders the membrane is thick, pale or bluish, and large amounts of mucus are present although in the later phase the membrane may be red and retracted.

The history on many of these patients often suggests a psychogenic state. Nash[1] remarked: "A functional disease of the nose is a condition of abnormal physiological response in which the mucous membrane of an organically normal nose enters into a state of hypo or hyperactivity. In the functional disease of the nose some agent external to the olfactory organ (but not necessarily external to the body) causes the nasal mucosa to underwork or to overwork, and such a response is always temporary and reversible in character."

This statement answers what is also seen to be present in many nasal disorders in pregnant women. It is clear that the causes are complex and that the rhinitis usually clears up at term. Because allergic and psychogenic factors are present in only a small percentage of the patients, it is more likely that the general adaptation syndrone, as suggested by Selye,[2] is responsible for these symptoms.

Pregnancy is a major event in the life of a woman. It assumes important significance when the expectant mother is an allergic patient. Fearful lest active symptoms disrupt her pregnancy, or that pregnancy will aggravate her allergic complex, the expectant mother is constantly in a state of anxiety. Anxiety and tension aggravate the allergic state.

Examination of the Nose

Examination of the nose in pregnancy reveals hyperemic and engorged turbinates. Some patients present polypoid changes in the turbinates and a watery discharge. The nasal smears will present eosinophils, but they are not prominent as in allergic nasal smears. Some patients begin to have symptoms in the second and third trimester. They give a history of having a "head cold" which does not disappear after the conventional cold remedies have been used.

Management

Management of these patients is as difficult as the diagnosis, therefore, it is of the utmost importance to make the patient as comfortable as possible until the termination of pregnancy. Intranasal medication and oral vasoconstrictors have been used with some success. It should be borne in mind, however, that the nose drops can be detrimental because some patients learn to depend on them. Antihistamines, tranquilizers and sedatives render only partial relief. Some patients receive satisfactory effects, especially those whose symptoms manifest themselves in the third trimester. Pollen desensitization injections have proved dangerous with involvement of the pregnant uterus as a shock organ, leading to abortion, as emphasized by Maietta.[3] Over 500 patients with chronic vasomotor rhinitis were treated by Fox[4] with sclerosing therapy. Fifty of these patients were pregnant. The results of this treatment were uniformly satisfactory. Grace[5] stated that he injects Cortone diluted with saline in minimal dosage into the attachment of the inferior turbinates avoiding the blood vessels anteriorly. The results of this local measure were very satisfactory. Surgical intervention during pregnancy to relieve nasal symptoms is unwise and is not recommended.

Comment

The nose in pregnancy presents a form of rhinitis with congestion, hypersecretion, epistaxis, obstruction and sneezing spells. The symptoms are not unlike those of allergy, but the typical allergic state is absent. The management entails use of remedies for relief without disturbing the pregnancy. Obviously the duration of the symptoms and treatment is limited. Psychogenic conditions which are present must be treated. Reassurance often has to be emphasized, but once the patient knows that her illness is temporary, stress and tension are relieved. I now treat these patients with oral vasoconstrictors, antihistamines and tranquilizers as indicated. In every instance cooperation with the attending obstetrician is imperative.

Summary

Signs and symptoms of the nose in pregnancy are discussed.

Changes of the nasal mucosa and its relation to ovarian function are observed during pregnancy.

Antigen-antibody mechanism usually is not a causative factor as is shown by lack of typical allergic symptoms.

Psychogenic factors are present in a small percentage of the patients, who respond favorably to "reassurance."

Cooperation of the obstetrician should be sought in the management of nasal problems which develop in pregnancy.

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9526 Northeast Second Avenue.

President's Page

How High Is Your Rent?

Throughout the ages various values have been put on practically everything in life. Some of these, such as commodities, labor, and entertainment, have evolved to monetary standards. We are living in a time when almost everything is based on a dollar value.

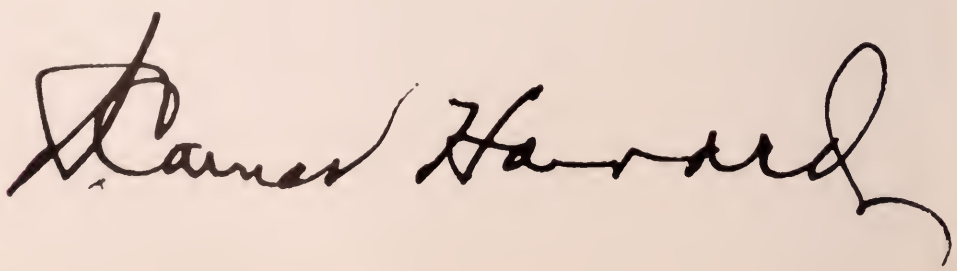
The statement has been made that no doctor ever becomes rich practicing medicine in terms of dollars. Some doctors by wise investments, inheritance, et cetera, may become wealthy dollarwise but not from the practice of medicine alone. Conceding that most doctors make a good living practicing medicine, one must also grant that they have to work hard to do so and have to keep on working. Probably most doctors hope to retire someday, but find it very hard to accumulate enough worldly goods to do so. Secretly, I feel, very few really want to retire completely from the practice of medicine for then they would not be in contact with those things which have been their very life.

In a recent speech Sen. Robert Kerr of Oklahoma made this statement: "Service is the rent you pay for the space you occupy." This means, as I interpret it, that doctors have the greatest opportunity of paying the highest rent of any group of people in the world. When a doctor is called upon for his service, the need may be little or it may be literally a question of life and death. In any event, the true doctor thinks of the service he can give, and the money he may get is only a secondary consideration. The satisfaction that the doctor gets in realizing that he has rendered a service to humanity is far greater compensation to him than money. Most doctors work hard with a resulting depreciation of their physical makeup. Why do these men keep on working when they know themselves of this depreciation better than anybody else? Is it because of the money they are making? In my opinion, no; they keep on working because they are dedicated to service.

As long as the medical profession has men of their caliber, we should have nothing to fear. This is our first bulwark in the fight against socialized medicine. When a man goes into medicine solely for the money he can get out of it, he should get into some other line of endeavor. Unless he can feel it a privilege to "pay his rent," he should not practice medicine.

This service of the doctor does not have to be in the practice of medicine alone, but should be characterized by his work in civic projects, his church, his family life and even in politics.

Practice the art of medicine as well as the science.



EDITORIALS

Diabetes and Cholesterol

The diabetic state is characterized by a general disturbance in metabolism. Abnormalities in fat and protein as well as carbohydrate metabolism are easily demonstrated. Recent studies have indicated the degree and the frequency of alterations in lipid metabolism in the diabetic. These lipid abnormalities are of special interest because of a probable relationship to vascular disease.

The altered pattern of lipid metabolism in the diabetic seems to be secondary to an inability to utilize glucose adequately. Present evidence suggests that this is primarily a result of inadequate insulin effect at the cell level. When glucose is not utilized, fat in the form of fatty acids is the major source of energy. Fat is an excellent source of two carbon units which are utilized in the Kreb's cycle. The release, however, of fatty acids from adipose tissue may exceed the energy requirements and the excess is diverted into the synthesis of cholesterol and ketones. If the rate of this reaction is rapid, the dominant resulting features will be ketosis, acidosis and coma. If fat catabolism occurs more slowly, ketones may be excreted by the kidneys or utilized by muscle. In the latter situation an elevation of the serum cholesterol may result. This sequence leading to hypercholesterolemia is encountered most often in the adult-onset diabetic.

The importance of an elevated cholesterol is twofold. First, there is indirect evidence that hypercholesterolemia is at least one factor in the development of arteriosclerosis, a complication that kills the majority of patients with diabetes. Whether this is a primary or a contributing factor in the genesis of vascular disease in the diabetic, there seems little doubt of its importance. Secondly, an increase in the serum concentration of cholesterol (or other lipids) indicates that attempts to restore metabolic abnormalities in the diabetic toward normal have been inadequate.

Most diabetics are slightly hyperlipemic even when they appear to be in good clinical control. The omission of insulin, in a person requiring insulin, is regularly followed by an increase in the serum concentration of free fatty acids, triglycerides, phospholipids and cholesterol. Changes in free fatty acids and triglyceride may be detected within hours after the omission of insulin. Usually several days of insulin deprivation are required for significant changes to be observed in the cholesterol and phospholipids. The reversal of the abnormal lipid pattern after insulin administration follows the same pattern. Hence, an elevated cholesterol—the lipid component most conveniently measured in most clinical laboratories—suggests a prolonged period of inadequate glucose utilization with associated mobilization of fat from adipose tissue. The fate of cholesterol is primarily one of excretion in bile; the amount of cholesterol excreted in bile appears to be rather constant. A change, therefore, in the circulating level probably represents an altered rate of synthesis. In the diabetic, synthesis may be increased during periods of insulin lack.

The frequency of hypercholesterolemia in "clinically controlled" diabetics is not known. It is not infrequent as indicated by the finding that 12 of 100 consecutive, well regulated patients returning to the Joslin Clinic for periodic evaluation had a serum cholesterol greater than 300 mg. per hundred milliliters; 32 of this group had a serum level above 250 mg., the upper limit of normal by the method used. An elevated cholesterol was observed most commonly in those diabetics above the age of 50.

An approach to the patient with diabetes and hypercholesterolemia should include:

1. Other causes for hypercholesterolemia should be excluded (hypothyroidism, nephrotic syndrome, liver disease).
2. More strict attention to treatment of diabetes is indicated. This includes an adequate diet plus insulin, or an oral hypoglycemic agent such as tolbutamide. It is preferable to try a basic diet which includes approximately 200 to 250 Gm. of carbohydrates, 70 to 100 Gm. of protein and 60 Gm. of fat. If the combination of diet and insulin results in more normal glucose utilization (as judged by absence of gly-

cosuria and lower blood sugars) a fall in the cholesterol level may be expected after two to three weeks. If the cholesterol concentration remains elevated after three months of adequate therapy, then a reduction in dietary fat and an increase in unsaturated fat may be considered. It seems highly desirable not to introduce multiple changes initially.

3. Triparanol (MER-29), in my opinion, should not be used. The action of this agent is to block the final step in cholesterol synthesis, leaving a complete cholesterol-like molecule (desmosterol) present in increased amounts. The effects of desmosterol on blood vessels may be similar to or even more detrimental than cholesterol. More important, this approach does not correct the primary disturbance, namely, inadequate glucose utilization. Similarly, other agents such as thyroid hormone derivatives and nicotinic acid are not indicated.

Finally there is increasing evidence that hypercholesterolemia may be a prediabetic manifestation. In any person, therefore, with an elevated cholesterol, especially if there is a family history of diabetes, a careful evaluation of glucose tolerance is indicated.

Joseph C. Shipp, M.D.
Assistant Professor of Medicine
University of Florida
College of Medicine
Gainesville

The Problem Juvenile and the Physician

In recent years physicians have become increasingly interested in the sociological and psychological aspects of medicine. An awakening awareness of responsibility in these fields is evident in articles written by physicians for both medical and lay magazines, in lectures, panel discussions and seminars included in medical meeting programs, and in the inclusion of their study in many medical school curricula. Physicians who care for children, especially, should and do see a growing opportunity to use their knowledge in the prevention of juvenile delinquency.

Juvenile delinquency, although far from being a strictly medical problem, is very much a physician's concern. The advice of the physician to parents—even to expectant parents—can provide the sort of understanding management which may prevent the development of attitudes and emotions which often lead to deviant behavior. What he does for and advises for any child from the moment of birth through the years that follow can obviously be tremendously effective in the child's personality and physical development. A recent study made by Ohio State University sociologists showed that once a pattern for good behavior has been set by and for a boy in preadolescent years, it is difficult to turn him into a delinquent.

The physician can help the handicapped child and his parents to handle or live with his problems in such a way that abnormal behavior will not result. He can be aware of other high risk situations that may lead to delinquency and can call upon the various resources available in the community to minimize the risk. When a child or adolescent begins to show antisocial attitudes, it is often the physician to whom the family first turns for advice; or the physician may note warning signs in his routine contacts with the child and his family before the parents are aware of them. Here he can help by just listening to the problems, by looking for undiscovered handicaps or disorders which may affect the child's behavior, and again by referring to proper adjunctive services. All communities have or should have a list of agencies or organizations equipped to assist in correcting some phase of delinquent or pre-delinquent behavior. The physician should know all these resources to which he can turn for assistance and from which his particular skills may be sought. Even so, his role in treatment, in most instances, will remain a limited one, in contrast to the major part he can play in the area of prevention.

Are physicians who deal with children the only ones interested in the juvenile delinquency problem? No, all physicians are citizens and

most are parents. All can contribute to the community awareness of the social aspects of the problem and can cooperate with others who have specific interests in this field, such as juvenile court personnel, law enforcement agents, social workers, religious leaders, educators and many others. No one person, agency, or group can hope to solve the total problem. It takes intergroup communication, firsthand knowledge of the local situation and a realistic appraisal of what one's own community can do.

Cornelia M. Carithers, M.D.
Jacksonville

Tuberculin Testing in the Schools of Palm Beach County

A great deal has been said and published recently regarding the elimination of tuberculosis. The Florida State Board of Health and its affiliates have a responsibility for leadership in this effort, and it is good to see a report from a County Health Department showing its use of the tuberculin test as a case-finding tool in tuberculosis.

In most parts of the country the tuberculin test is recognized as an important and necessary case-finding tool. It has become more valuable because of the decrease in number of positive reactors and proportionate decrease in active cases of tuberculosis. It is possible that testing of all persons, with follow-up of positive reactors, will be the major method of control.

The report by Dr. Brumback and his associates in this issue of The Journal indicates a splendid spirit of cooperation between the private physicians and the county health department. The follow-up of contacts is very important, yet time-consuming. When private physicians take on a thorough job of follow-up, they do so at personal sacrifice; however, this attitude of cooperation eventually will eradicate tuberculosis.

In this report the number of adult contacts who had chest x-rays seems low, but contacts spread out in ever widening circles. According to Dr. D. J. Wharton, Director, Division of Tuberculosis Control, Florida State Board of Health, "The source of the child's infection will be in the parents only about one third of the time. Uncles, aunts, grandparents and other relatives make up another third. The final third will be in other adult associates such as teachers, household employees, baby sitters and school bus drivers. Very few health departments have adequate personnel to explore all the possibilities of contacts, but the additional use of volunteer workers might bring good results."

The importance of testing 100 per cent of the group selected is apparent, and a good promotional and educational program is essential prior to the testing. In many areas of the country the health departments are using the American School Health Association certification plan. The associated promotion, education, and follow-up can lead to total community or county case finding, as well as eliminate the tuberculosis problem in the schools, according to a report from Newton County, Missouri.

The fact that there was no decline in the percentage of reactors during the four year period and an increase in the percentage of colored children reactors is an interesting finding. This may indicate that the program is not intensive enough, that each year there has been an added effort to survey those not previously tested, or that it may be explained on the basis of the migratory nature of these individuals.

All in all, the results were very good and show what can be done by a cooperative effort. For 21,000 tests a total of 33 new cases of tuberculosis was found .

Tuberculin testing provides information on the prevalence of active tuberculosis in a community. When annual testing shows no reactors in a school, there is little tuberculosis in that community and an x-ray survey is unnecessary. As the prevalence of tuberculosis shrinks into smaller and smaller nests, tuberculin testing becomes the only indication to other case detection methods.

The census of patients in the three State Tuberculosis Hospitals is approximately the same as it was a year ago. In the previous four or five years there was a drop of approximately 100 patients per year. The fact that this has not happened this year is an indication that tuberculosis has not been eliminated and further efforts must

be exerted toward case finding. Every means available in the control of tuberculosis must be put into use and the money and personnel made available to the health departments for this purpose.

Drs. Brumback and Kaufman are to be congratulated on a fine job. I hope to see further reports from them showing a drop in positive reactors and active cases, and may they reach the goal of 100 per cent participants.

LAWRENCE C. MANNI, M.D., DIRECTOR
STATE TUBERCULOSIS BOARD
TALLAHASSEE

In Memoriam
Herbert L. Bryans
Past President

In the passing of our beloved Herbert L. Bryans on June 8, 1961, the Florida Medical Association lost a distinguished and picturesque veteran member. In a profession whose members adhere to the principle of service to others, few of us have been able to approach the high standard of devotion to that ideal established by Herbert. In community, state and national medical circles he gave generously of himself and his talents that others might benefit.

Dr. Bryans was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians. He was a life member of the Florida Medical Association and the American Medical Association.

As a member of the Trustees of the Escambia County Schools, and in recent years as chairman of this group, he contributed materially to the cause of public education. In other community services he led in the movement for the establishment of the Escambia County Health Department and more recently gave impetus toward the construction of the new Escambia General Hospital. He took a leading part in the establishment of the first school for practical nurses in Florida at the Pensacola Vocational School and aided the Pensacola Junior College as a member of its advisory council in the formation and guidance of its School of Nursing. In January 1961 he was awarded a certificate of merit by the Escambia County Medical Society for his outstanding work in the field of nursing education. He was a board member of the Escambia County Tuberculosis Association and of the Escambia Blood Bank, and served for more than 10 years as a director of the local branch of the National Infantile Paralysis Foundation.

Dr. Bryans will long be remembered for his statewide service as president of the Florida State Board of Health for a period of 16 years, a term unequaled by any other holder of that position. During this period he did not miss a single meeting of the Board of Health and in addition gave unstintingly of his time between meetings in the furtherance of the activities of that important board. He aided the Florida Vocational Rehabilitation Service in the establishment of medical standards for the state and otherwise contributed to vocational rehabilitation at state and local levels.

He was an honored and respected member of the medical profession where he truly exemplified the idea of service and the medical code of ethics. He materially contributed to his great profession by service as the president of the Escambia County Medical Society, as a founder and president of the Gulf Coast Clinical Society, as president of the Florida Medical Association and for many years as a delegate from Florida to the American Medical Association. He served his country overseas in World War I as an officer in the Army Medical Corps.

A man of becoming modesty, of temperate and modest habits, with an intense interest in serving others, he walked humbly before his Maker in the service of his church.

Because he so fully committed himself to a useful life, Herbert Bryans will be sorely missed not only by his community, where he was held in such affectionate esteem, but throughout the state and national medical circles.

WALTER C. PAYNE SR., M.D.
PENSACOLA

Papers for Annual Meeting

The Committee on Scientific Work requests that members desiring to present papers at the Association's Annual Meeting May 9-13, 1962, submit an abstract prior to November 20. Those planning scientific exhibits should submit a short description to the Committee at P.O. Box 2411, Jacksonville 3. See advertisement on page 178 of this issue.

MEDICAL NEWS

Readership Survey Response To Be Used in Planning Future Issues of The Journal

Within the past few months, each member of the Florida Medical Association has received a questionnaire concerning The Journal of the Florida Medical Association. In developing this query, our purpose was to obtain a maximum of information to be used in formulating future issues of The Journal, while requiring a minimum of time and effort from each member polled. Of the 4,202 questionnaires which were mailed, to date 893 have been completed and returned—a 21 per cent response from our readers. From authoritative sources we have learned that a 10 per cent return is as much as can usually be expected from such a mailing. We believe, therefore, that this response is an indication that The Journal has a place in the Florida Medical Association, and is serving a purpose for our membership.

In developing the future issues of The Journal, your comments, favorable and unfavorable, will serve as a guide in our efforts to give you the type of magazine you want. Immediately and in the near future many of you will find your suggestions incorporated into The Journal, and used in formulating its policies.

The primary purpose of The Journal is to reflect, on a scientific level, the intellectual expressions of the members of the Association. We agree that any scientific presentation, to be of interest, should be concisely written and wisely conceived. In an effort to achieve this end, the editorial board will review all submitted work with care and exercise selective judgment in choosing those works to be accepted for publication.

General information, state personal news, listing of state and county officers and committees, obituaries, announcements for ancillary organizations—all these will be reviewed with a critical eye, using your evaluation and comments as a guide.

An effort is being made to bring scientific knowledge to our readers throughout the year in the form of reports directly following medical meetings within the state. Arrangements are under way which will bring us closer to the scientific investigation being conducted in the medical schools of our Southeastern United States. A section of The Journal devoted to a clinico-pathological conference is being contemplated.

The Journal of the Florida Association
Readership Survey

Do You Read?	Often	Seldom	Never	Total
Table of Contents	663	103	25	791
Scientific Articles	523	281	10	814
Abstracts	343	362	91	796
President's Page	409	311	74	794
Editorials	499	260	41	800
News (Meetings, PG Courses)	439	239	89	767
Others Are Saying	237	291	178	706
Blue Shield	280	324	150	754
State News Items	435	245	87	767
Births and Deaths	270	310	177	757
Classified	158	320	260	738
Obituaries	238	261	258	757
New Members	304	269	183	756
Book Reviews	171	341	222	734
Ads Preceding Text	293	276	160	729
Ads Within Reading Matter	301	281	145	727
Ads on New Drugs	379	267	122	768
		Yes	No	Total
List of Newly Licensed Doctors		532	228	760
FMA Officer and Committee List		583	169	752
County Medical Society Officers		565	180	745
Proceedings of Annual Meeting		618	121	739

These and other projects we are undertaking in the belief that they will give a better journal to the many of you who now enjoy The Journal, while at the same time furnishing information requested by your comments. You, the reader, must be the judge of our efforts. It is only through your constructive criticism that we can continue to give you a journal you will enjoy.

Let us know what you think.

The Health Insurance Council What It Is and What It Does

More and more physicians are hearing about the Health Insurance Council, principally because of its efforts to simplify and standardize insurance claims forms. Many doctors are aware also of the Council's endeavor to set up problem-solving mechanisms, so that voluntary health insurance can continue to grow and provide effective health care financing without becoming a burden to anyone. There are many physicians, however, who do not know about the Health Insurance Council, and others very likely have questions about whom it represents, its objectives, and how it functions.

The Health Insurance Council is a federation of eight insurance associations. The more than 700 member companies of these associations issue 90 per cent of the health and accident policies written by the insurance business.

The council was organized in 1946 to:

1. Provide information to physicians, hospitals and allied health care groups on health insurance, its nature and progress.
2. Confer with the providers of health services on problems of common concern, and aid in their solution.
3. Report and interpret to the insurance business the attitudes and needs of the health care professions.

On behalf of the nation's insurance companies, the Council serves as a central source of information and counsel to physicians, hospitals and others in the health care field on all aspects of health insurance. Through a broad range of activities the Council seeks to promote cooperation and understanding between those who administer health services and those who help finance its cost, to the end that the insurance business may provide more effective and satisfactory financing of hospital and medical care expenses for insured patients and their families.

OTHERS ARE SAYING

"Wolf!"

Abraham Ribicoff, late statesman and Governor of Connecticut, now having become politician and Secretary of Health, Education and Welfare, charges the AMA with making misleading attacks on President Kennedy's Medical Care for the Aged and crying "wolf." This was in a speech read for him at the Third Annual Conference of National Organizations concerned with the aging. The Secretary was unable to deliver this speech personally because of an attack of laryngitis. In the address, Sec. Ribicoff made the remark that he was disturbed by the advertisements of the AMA and that he did not believe they represent the views of the working doctors of our land. He further contended that President Kennedy's program was incorrectly labeled "Socialized Medicine for the Aged," for under socialized medicine all hospitals and health facilities would be owned and operated by the government, with all medical personnel on government salaries like firemen and policemen. This appeared in the papers in April, while in March he had accused the AMA of exercising very strong sanctions against individual doctors who speak up against their policies.

Called one of the toughest unions in the world by Robert C. Ruark, into which the physician is blackmailed, the AMA is now more than ever before being made the object of public scorn by the press, excoriated for sins it has never performed, misrepresented, and mercilessly maligned.

A recent editorial in the New England Journal of Medicine says "criticism that cuts more deeply, however, is that which, basically unfactual, comes from members of the Association themselves, or from eligible physicians who have not joined the organization. Not joining or resigning as a member accomplishes nothing. . . .The house of delegates sets the policies. The delegates are elected by the members of their respective state medical societies whom they represent on the floor of the house. A physician who strongly opposes an AMA policy may, on district, county and state level, work to change it. If he can convince the majority of physicians in his society that his stand is just and correct, the society's delegates will espouse his cause. The physician who resigns from membership or refuses to join

as a matter of principle weakens his own cause. The physician or non-member who criticizes the association, without a knowledge of its structure and purpose, without participating in the affairs of his own state medical society, and without a clear understanding of the facts on the issue he criticizes, plays into the hands of those critics whose objective is disorganizing medicine. There are just reasons for criticizing the private practice of medicine as conducted by some individuals, as in every other profession in which the sale of its members' services provides them with their living. There are those in medicine who are incompetent and who exploit the physician-patient relationship to their own advantage."

Now, as the voices of the critics of organized medicine become louder, the AMA needs the concerted support of all physicians, both members and non-members. If our policies are poor, if our horse-and-buggy attitudes prevent us from seeing present socio-economic changes, if the voice of the individual doctor is unheard in the multitude, let us correct such things. But let us not forget, that to continue the practice of medicine in the manners which we think are best, every doctor must express his opinion, cast his vote, work on a committee and unselfishly add his labors to all others for the teamwork needed to provide better and better medical care for every citizen in our land.

Clyde M. Collins, M.D.
Monthly Bulletin
Duval County Medical Society
June 1961

LETTERS TO EDITOR

In this column, The Journal encourages open discussion of controversial subjects. Letters, to be published, should be in good taste and signed by the author. The opinions expressed are those of the author and not necessarily of The Journal.

July 7, 1961

Dear Sir:

Recently a number of letters have circulated among doctors around the state, seriously and in my opinion unjustifiably attacking the position of Senator George Smathers, specifically in regards to the recent Senate confirmation of Wilbur Cohen as Assistant Secretary of Health, Education, and Welfare.

Much of this caustic criticism is based primarily on a recent mailing of Marjorie Shearon's "Challenge to Socialism" wherein specific Senate floor action of Senator Smathers is reported as reflecting his opposition to the doctor's position. The circumstances as recorded are essentially true, but because the whole story has not been told, it serves as a good example of a circumstantial appraisal of a situation factual on the surface but only superficially in accordance with the whole truth.

My personal contacts with the Senator on all matters pertaining to medicine have been very close over a long period of time and in justice to him and to our position, I believe the doctors of Florida are entitled to a little more of the background necessary to an honest appraisal of the Senator's actions.

In the first place it is necessary to know how the Senate operates. Visitors to the Senate gallery are repeatedly amazed that very few Senators are on the floor at any one time unless a major issue or a major vote is at stake. The mechanics of operation are such that the Senators are busy in committees or in their offices and only those with official business are on the floor at any one time. Because of this, however, it is necessary that a sort of officer of the day always be present to represent each party so that legislation already agreed upon or assured of passage cannot be sidetracked or voted down by a handful of votes present. Each day a member of each party sits as a sort of watchdog to protect legislation or senatorial action already decided upon and with sufficient votes for passage if the entire Senate should be assembled. On the day in question, Senator Smathers was the "officer of the day" and was merely performing a routine chore to which he had been assigned.

In the case of Wilbur Cohen the facts are essentially these:

1. He was a presidential appointee and in practice unless there is a major objection sustained by an investigation proving unfitness, the policy is to allow a president to appoint whom he pleases.

2. Many objections including Marjorie Shearon's challenge to Wilbur Cohen were heard by the Senate Finance Committee. The Committee supported by careful FBI investigations repudiated the accusations. The record is very clear and there was only one vote cast in the Committee against the confirmation of Wilbur Cohen. At the time that the vote was taken, Senator Smathers was in Florida and took no part in this action.

3. Wilbur Cohen is looked upon as the ablest actuarial expert in the field of social security now residing in Washington or anyplace else. During the eight years of the Eisenhower Administration despite their opposition to his philosophy, this man was repeatedly called when his technical assistance was needed. I have been informed that even the Kerr-Mills bill was put together by Wilbur Cohen in accordance with the dictates of Mr. Mills and Senator Kerr.

4. Had the entire Senate been called together, Cohen's nomination would have gone through by a vote of 3 or 4 to 1, according to conservative estimates.

I will admit that Senator Smathers played well the political roll to which he was assigned as a member of the party, but he merely assured final action of confirmation of Mr. Cohen without bringing the entire Senate into the chamber to accomplish the same previously determined result.

Senator Smathers has consistently defended our position and is one of our very real allies in the Senate and the Senate Finance Committee. Politics is the art of the possible and the votes that count are those on major and basic issues where principles are involved. There are few men in the Senate who have been as consistent as Senator Smathers in demonstrating their ability, their intelligence and their capability for independent thought and action. No physician can demand of any representative or senator that he always vote the way he thinks he should, but as a representative of the Florida Medical Association, I can factually state without equivocation that Senator Smathers has defended our position repeatedly, not because we are physicians, but because we have consistently demonstrated the rightness and the soundness of our position.

Doctors frequently get upset when newspaper, magazine and television reports as interpreted by nonmedical people fail to reflect the true story. A similar situation exists in the field of politics, the machinery of representative government, and we must guard ourselves against accepting as fact, assertions resulting from lack of understanding of the mechanics of representative government. In the junior Senator from Florida, we have a strong, able and intelligent ally who has always been willing to hear our side of the story and in the future, as in the past, will continue to support our point of view as long as we can justify the rightness of our position.

Yours most sincerely,
(Signed)
Edward R. Annis, M.D.

Medical Complications of Pregnancy

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November 9, 10, 11, 1961

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and
Members of the Faculty of
Emory University School of Medicine
69 Butler Street, S. E.
Atlanta 3, Georgia

BLUE SHIELD

Cost Secondary to Coverage

Americans are keenly health conscious. They have become equally aware that one of the basic economic realities of modern life is being prepared to meet the expenses, should illness strike. Floridians evidently are seeking the most protection they can buy with their health benefits dollar, but they are not necessarily hunting in the bargain basement. They are finding quality merchandise appealing, recognizing that it must necessarily be more expensive.

This realistic acceptance of greater benefits at increased cost has been effectively demonstrated in recent months. Early this year the new and better "K" Blue Shield contract was made available to subscribers already covered under, or eligible for, the less expensive "J" contract with its more restricted scope of benefits. The appeal of the "K" is such that, today, approximately one out

The Weeders, Van Gogh, Bernard Koehler Collection, Berlin



S T R A I N

Essential in moving external masses, but potentially dangerous in moving the bowels, since vascular accidents may be precipitated in heart patients by excessive straining at stool. For cardiac patients with constipation, Metamucil adds a soft, bland bulk to the bowel contents to stimulate normal peristalsis and also to hold water within stools to keep them soft and easy to pass. Thus Metamucil, with an adequate water intake, induces natural elimination with a minimum of straining. Metamucil also promotes regularity through "smooth-age" in all types of constipation.

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SEARLE

of every five subscribers, exclusive of those enrolled in the federal program, has this greater protection although it means an increase in the amount he must pay to the extent of 47 per cent for a one person contract, or 76 per cent for a family contract, for subscribers paying directly to the Plan. The percentage increase is slightly less for those enrolled through groups. It is noteworthy that subscribers and employers are not unaware that the Schedule of Benefits applicable to the "K" contract more nearly meets the usual fee of their doctors, and that it assures more reasonable compensation when professional services are rendered to low income patients.

One year ago the federal government put into effect a vast, comprehensive health benefits program, to which it contributed on an employer-employee, share-the-cost basis, comparable to that prevalent in business and industry. These federal employees not only were given a choice of health plans, but also were given the option of an exceptionally broad set of benefits, at a stipulated rate, or a more restricted scope of benefits at a lower rate to the subscriber, the government's contribution being the same in either case. Under the high option, the employee's share exceeded the cost of the local Plan coverage which was previously available to him.

When the enrollment figures were in, they showed that over 54 per cent of the federal employees had selected the Blue Cross-Blue Shield Service Benefit Plan. They also established that over 80 per cent elected the more expensive high option with its broader coverage, indicating that realistic benefits often outweigh cost when it comes to providing protection against the expenses of illness.

NEWS & PERSONALS

Dr. Edward R. Annis of Miami has been appointed an Editor-at-Large on the staff of "Medical Economics."

Dr. Samuel M. Day of Jacksonville has been presented a plaque in appreciation of his service to St. Vincent's Hospital in Jacksonville.

Dr. Robert B. Lawson of Miami, Professor and Chairman of the Department of Pediatrics at the University of Miami School of Medicine, has been appointed interim dean of the School effective July 1.

Dr. Louis J. Polskin of Lakeland participated in the course "Management of Mass Casualties" held late in May at the Army Medical School at Fort Sam Houston, Texas.

A Seminar in Neurology will be presented September 28-30 and a Seminar in Orthopedic Surgery on October 26-28 at the University of Florida College of Medicine at Gainesville. Information on the two Seminars may be obtained by contacting the Division of Postgraduate Education, University of Florida College of Medicine.

Dr. Clifford C. Snyder of Miami has been chosen president-elect of the Southeastern Society of Plastic and Reconstructive Surgeons.

Dr. Eugene G. Peek Jr. of Ocala and Dr. Ashbel C. Williams of Jacksonville have been appointed as members of the State Board of Health by Governor Farris Bryant.

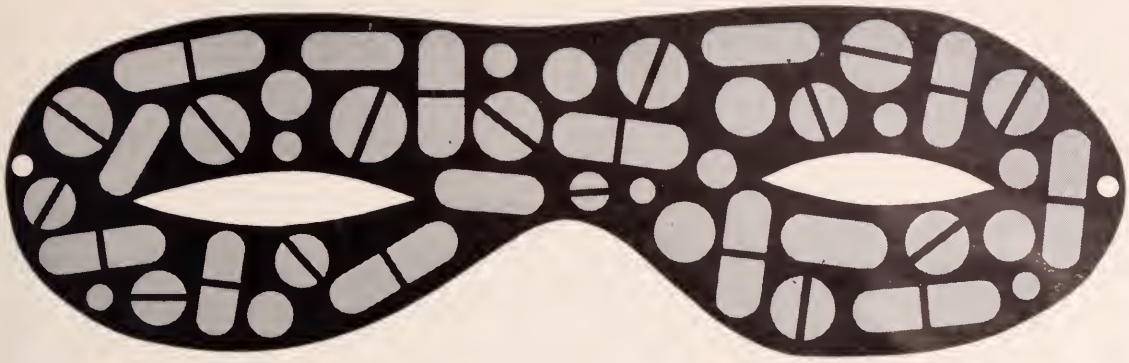


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drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
formerly Medical Director of the
Food and Drug Administration

Smith Kline & French Laboratories, Philadelphia SK&F

Dr. Thomas C. Dickinson of Orlando was guest speaker at the recent monthly meeting of the Lake County Medical Society held at Mount Dora. Dr. Dickinson discussed the pathogenesis, diagnosis and treatment of myocardial infarction.

Dr. William A.D. Anderson of Miami, Professor and Chairman of the Department of Pathology at the University of Miami School of Medicine, has been named exchange professor of pathology at the University of Cape Town, South Africa, and will teach there from August to December. He will lecture at the South African Institute for Medical Research, Johannesburg, the University of Natal, Durban, and other African medical schools.

Dr. George T. Harrell of Gainesville, Dean of the University of Florida College of Medicine, was guest speaker at the first annual Dr. Edward Jelks testimonial dinner held late in June at the Duval Medical Center at Jacksonville.

Dr. Kenneth A. Morris of Jacksonville has returned from visiting hospitals and clinics in England, France and Switzerland.

Mr. Jake K. Ball, special representative of the Chamber of Commerce of the United States, was the principal speaker at the June meeting of the Escambia County Medical Society. The title of his presentation was "Our Heritage in a Democratic Society—Is It Worth Saving?"

Approval of 10 applicants for state medical scholarships has been announced by the Florida State Board of Health. The successful candidates were recommended by the Advisory Committee for Medical Student Scholarships of which Dr. Melvin M. Simmons of Sarasota is chairman. These with their schools include: Thomas J. Calhoun, Buford Gibson Jr., and Betty Jo Johnson, Meharry Medical College; George D. Finlay Jr., Webb B. Olliphant Jr., Thomas J. Philpot, David O. Westmark and George N. Wiggins, University of Florida College of Medicine; James C. Phillips and Joseph T. Rabban Jr., University of Miami School of Medicine.

Dr. Woods A. Howard of Lakeland has been attending a postgraduate course in medicine at the Harvard Medical School in Boston.

(Continued on page 178)

ULTRASOUND
combined with
ELECTRICAL STIMULATION

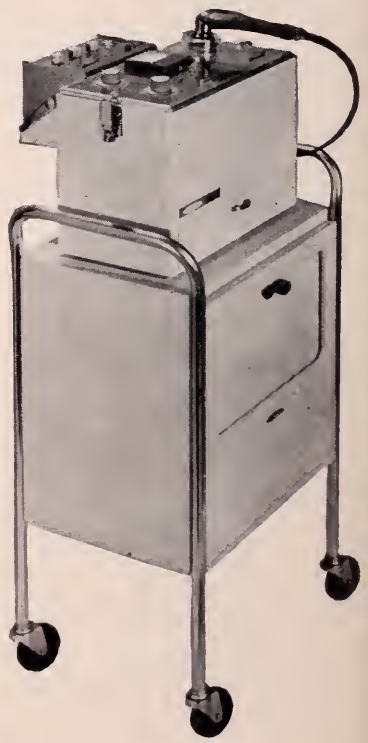
For those interested in combining electrical stimulation with ultrasound, the MS-300 Stimulator may be connected to the UT-400 Ultrasound unit, as illustrated. The treatment applicator serves as the active electrode for the stimulating current and at the same time as a transducer for ultrasonic energy.

The patient experiences a stimulating skin sensation from the MS-300 current, but no sensation from the ultrasound unless applied in excess dosage.

The combination of electrical stimulation and ultrasound can also be used to advantage in locating trigger areas when dealing with painful conditions. A trigger area chart will be furnished on request.

The MS-300 has been approved by the Federal Communications Commission for use in conjunction with the Burdick UT-400 Pulsed Ultrasound unit.

Individual prices: MS-300 $215; UT-400 $395, EKS-37 stand $50.



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- ✳ Contains 50% liquid corn oil and 50% partially hydrogenated corn oil!
- ✳ Delicious flavor like the sweet, high-price spread!
- ✳ Fresh-Frozen—available only in grocers' frozen food cases!



Now, Fleischmann's announces a new unsalted margarine for patients on low-sodium diets, and for those who simply prefer the sweet taste of an unsalted spread. It's new Fleischmann's Sweet (Unsalted) Margarine, made from 100% corn oil. This new margarine has a linoleic acid content higher than any other corn oil margarine . . . and ten times higher linoleic acid content than the high-price spread. Thirty percent (30%) of the fat in Fleischmann's is polyunsaturated.

Smooth, Fresh Flavor Preserved By Exclusive Fresh-Frozen Process

This new unsalted margarine has a light, fresh flavor your patients will find delicious. And because it contains no salt or other preservatives, it's Fresh-Frozen for flavor protection. Your patients can be sure it's always fresh and pure.

Although this new margarine is Fresh-Frozen, the quarter in use may be kept in the refrigerator as any other spread. The remaining quarters should be stored in the freezer.

For Patients On Sodium-Restricted Diets

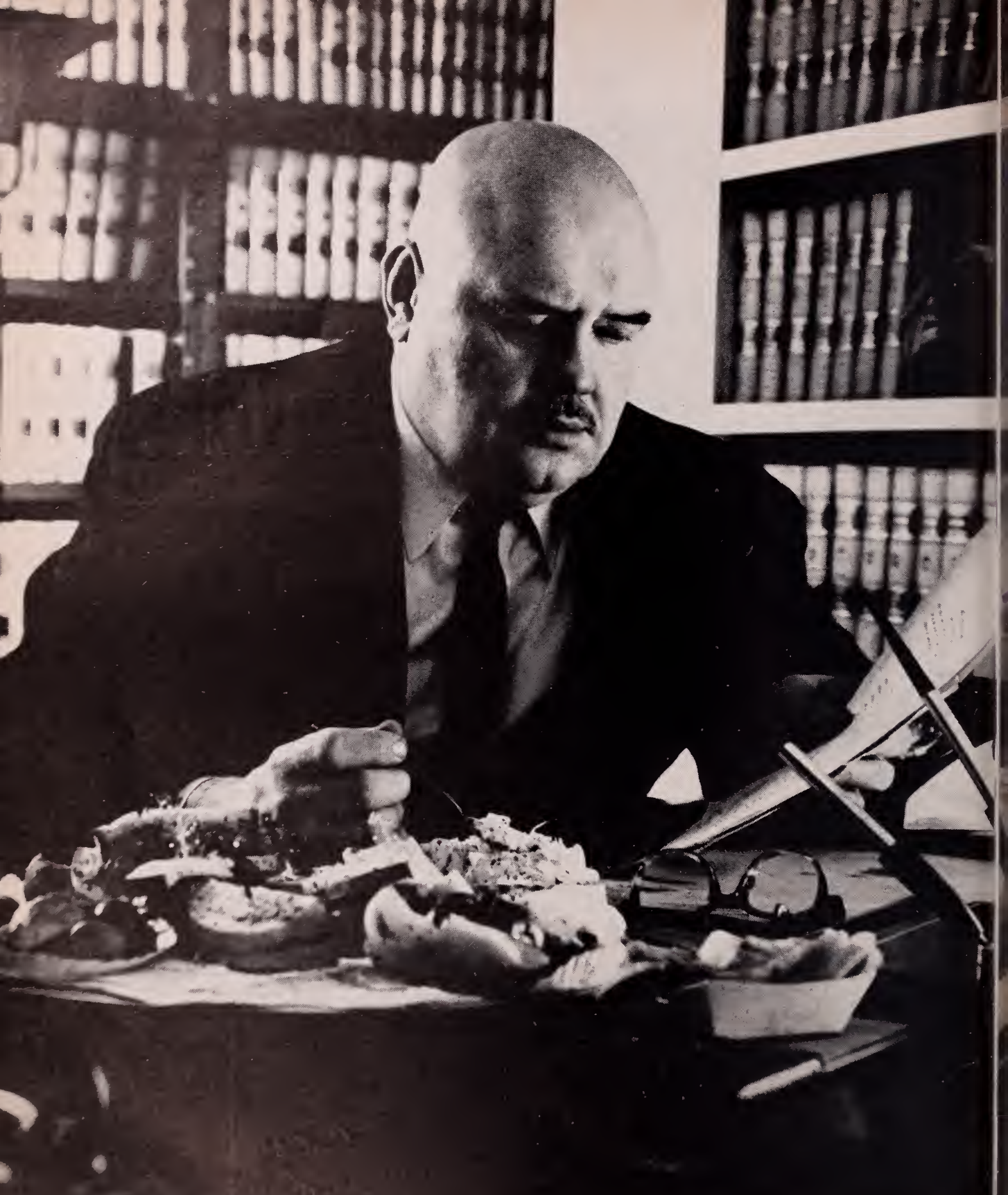
If your patients need sodium restriction, recommend delicious new Fleischmann's Sweet (Unsalted) Margarine. It's ideal as a table spread and for cooking. It comes in a *bright green* foil package and is found in the grocer's frozen food case. Remember Fleischmann's is the first and only unsalted margarine made from 100% corn oil.



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for "special-problem" patients... when corticosteroid therapy is indicated

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in rheumatoid arthritis

Aristocort®

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OUTSTANDING FOR "SPECIAL-PURPOSE" THERAPY

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for example:

SPECIAL PROBLEM: ANXIETY-TENSION

When triamcinolone was used, euphoria and psychic unrest rarely occurred. (McGavack, T. H.: *Clin. Med.* 6:997 [June] 1959.)

SPECIAL PROBLEM: OVERWEIGHT

No patient developed voracious appetite on triamcinolone. Preferable for the overweight person whose appetite is undesirably stimulated by other steroids. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

Hypertension did not result from triamcinolone therapy. Existing hypertension was reduced sometimes. This may have been due to lack of sodium retention. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).
Also available—syrup, parenteral and various topical forms.

Lederle

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.

LE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

(Continued from page 174)

Dr. Ashel C. Williams of Jacksonville attended a Board of Directors meeting of the American Cancer Society held in June at Seattle, Wash. He also attended a meeting of the Cancer Committee of the American College of Surgeons there.

Dr. Irving M. Essrig of Tampa moderated a panel which discussed the operations of Blue Shield at the June meeting of the Hillsborough County Medical Association. Members of the panel included Dr. S. Carnes Harvard of Brooksville, President of the Florida Medical Association; Dr. Ralph M. Overstreet Jr. of West Palm Beach, chairman, and Dr. John S. Stewart of Fort Myers, member, Committee on Advisory to Blue Shield; Dr. Russell B. Carson of Fort Lauderdale, president, and Mr. H. A. Schroder of Jacksonville, executive director, Blue Shield.

Dr. Paul A. Mori of Jacksonville attended the convention of Rotary International held in Tokyo, Japan, and continued around the world visiting Hong Kong, Bankok, India, Moscow, the Holy Land and Europe.

Dr. George N. Papanicolaou, Professor Emeritus at Cornell University Medical College, will become director of the Cancer Institute at Miami on October 1.

MEETINGS

August

Postgraduate Obstetric-Pediatric Seminar, Aug. 17-19, Colonial Inn, St. Petersburg Beach

September

Florida Society of Anesthesiologists, Sept. 16-17, The Carosel, Daytona Beach

Seminar in Neurology, Sept. 28-30, College of Medicine, University of Florida, Gainesville

October

Florida Academy of General Practice, Oct. 6-8, Hotel Diplomat, Hollywood

Seminar in Orthopedic Surgery, Oct. 26-28, College of Medicine University of Florida, Gainesville

November

2nd Postgraduate Medical Seminar Cruise, Nov. 2-12, S. S. Hanseatic, College of Medicine, University of Florida, Gainesville

Florida Pediatric Society, Nov. 9-12, Cherry Plaza Hotel, Orlando

December

Florida Obstetric and Gynecologic Society, Dec. 1-3, Gault Ocean Mile Hotel, Fort Lauderdale

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A PAPER – OR A SCIENTIFIC EXHIBIT

You would like to present at the Florida Medical Association's Eighty-Eighth Annual Meeting, May 9-13, 1962, Bal Harbour?

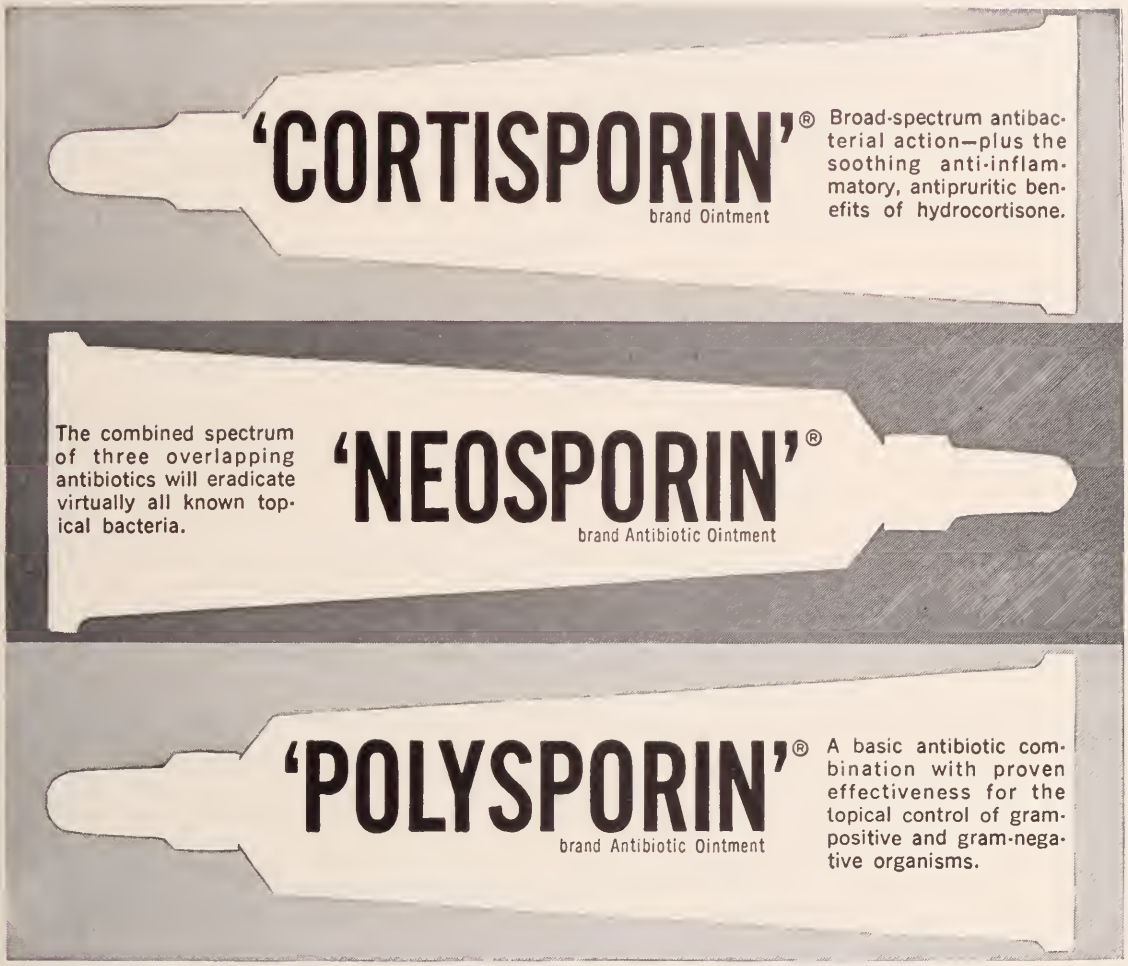
Scientific Paper—An abstract of 50 words should accompany application
Exhibit—With application, send resume of subject and photograph or sketch
Deadline for abstracts is November 20

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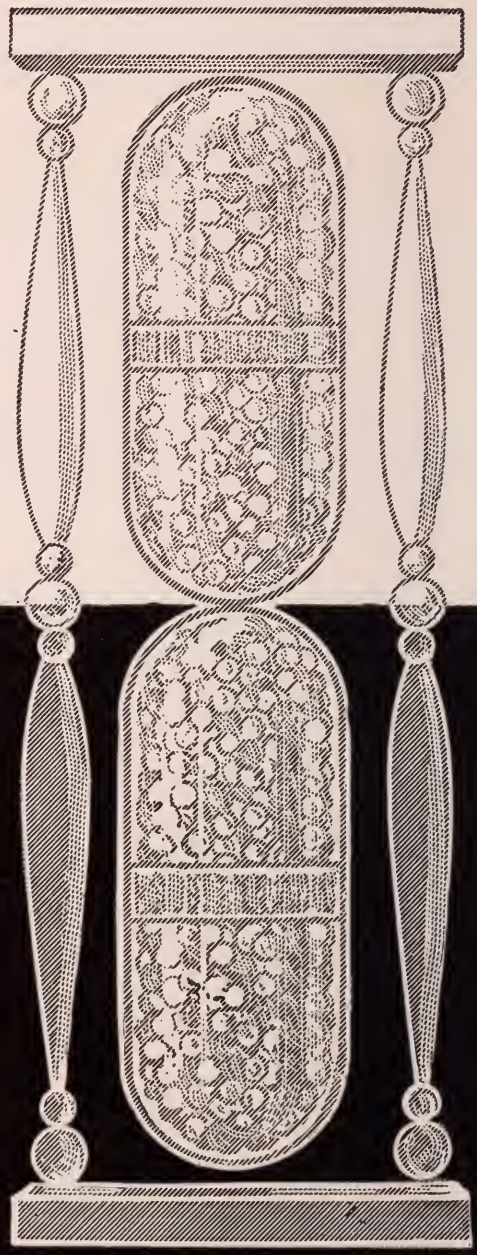
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Now, for the first time, the benefits of steroid therapy are enhanced by sustained release PREDLON PELSULES.

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PAPAIN IS THE KEY

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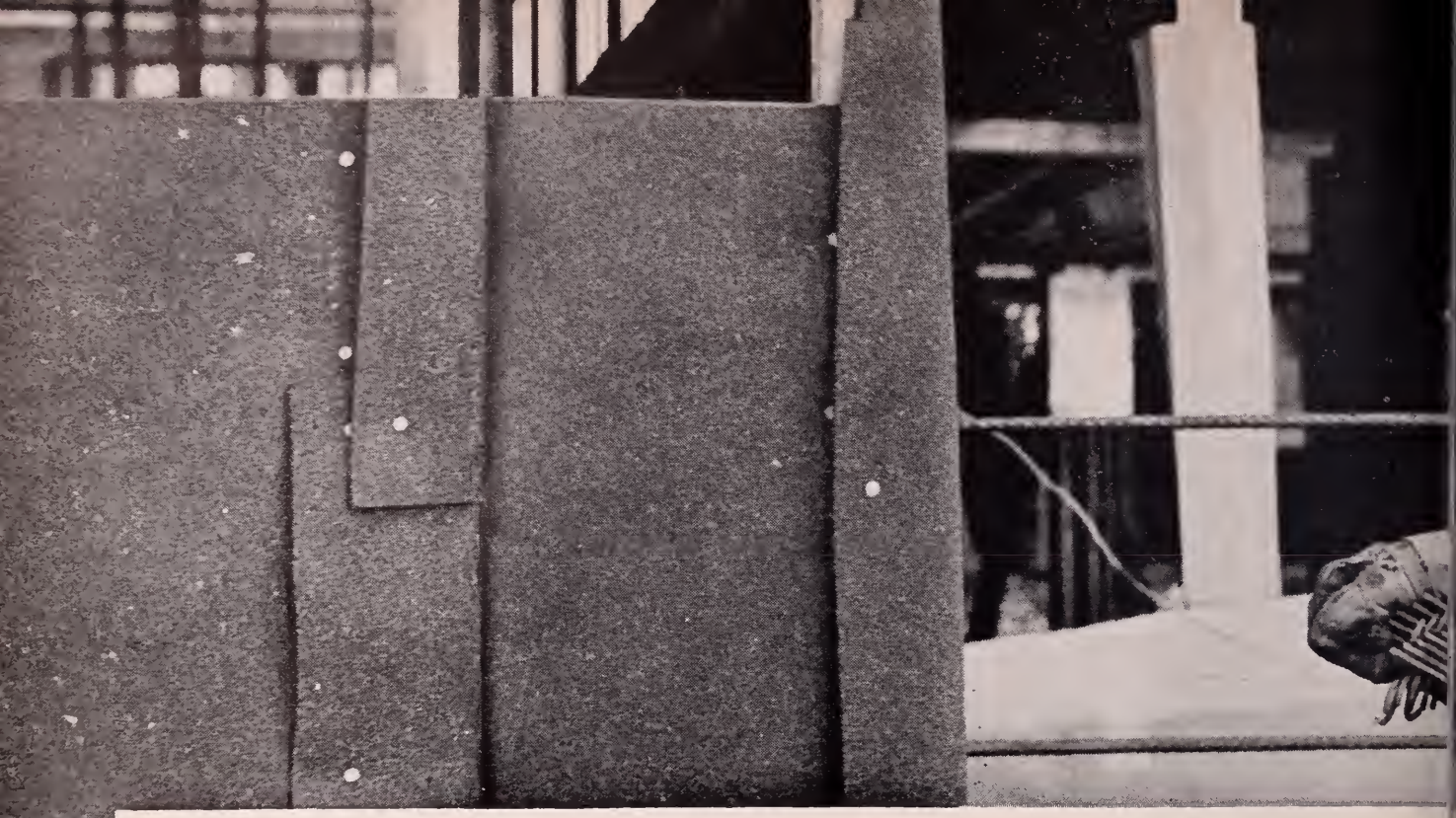
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Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only with higher dosages. Soma is available in 350 mg. tablets. Usual dosage is 1 tablet q.i.d.

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Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

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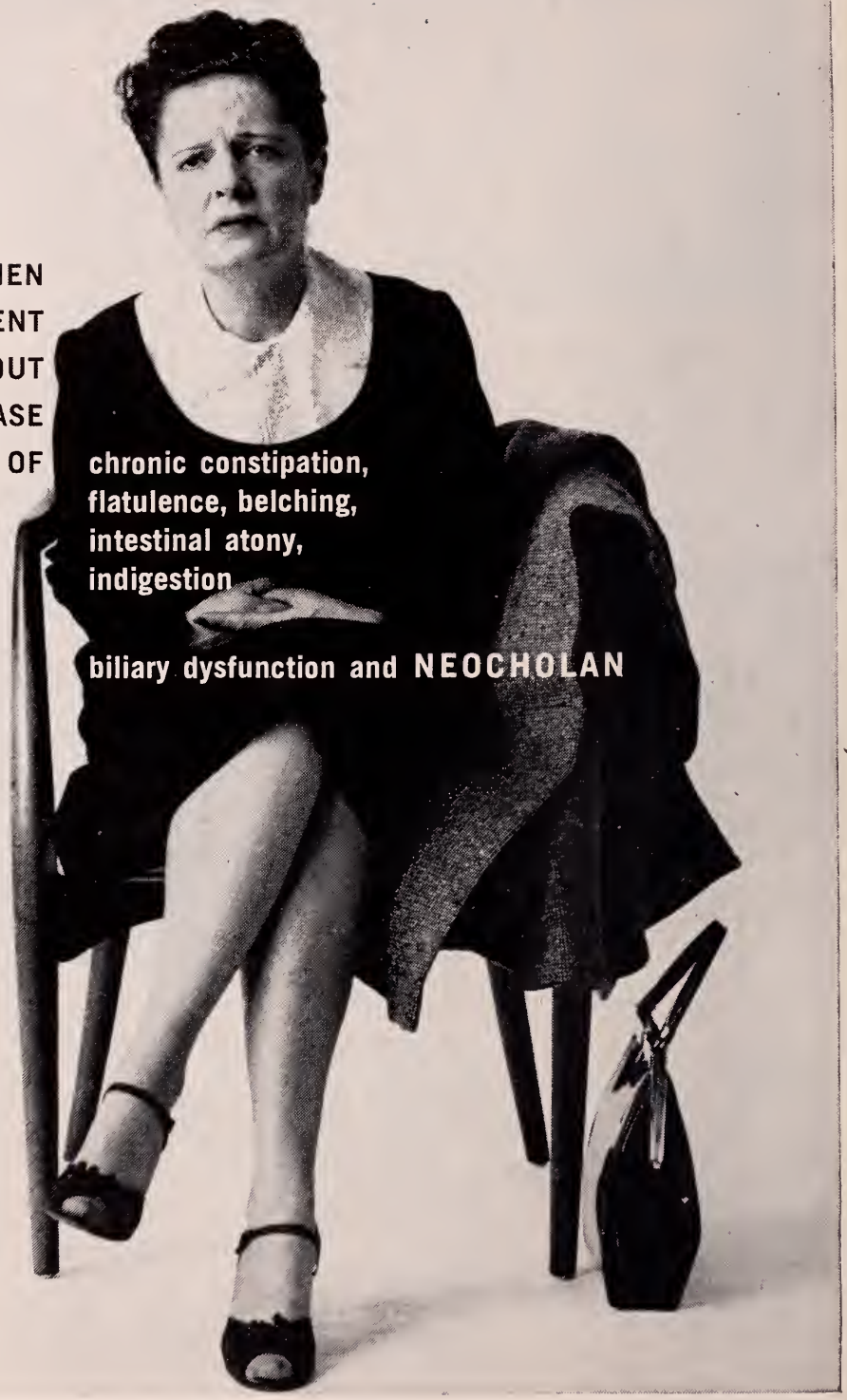
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COMPLAINS OF chronic constipation, flatulence, belching, intestinal atony, indigestion

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for the tense and
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1 simple dosage schedule relieves anxiety dependably — without the unknown dangers of "new and different" drugs

2 does not produce ataxia, stimulate the appetite or alter sexual function

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Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS*—400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).
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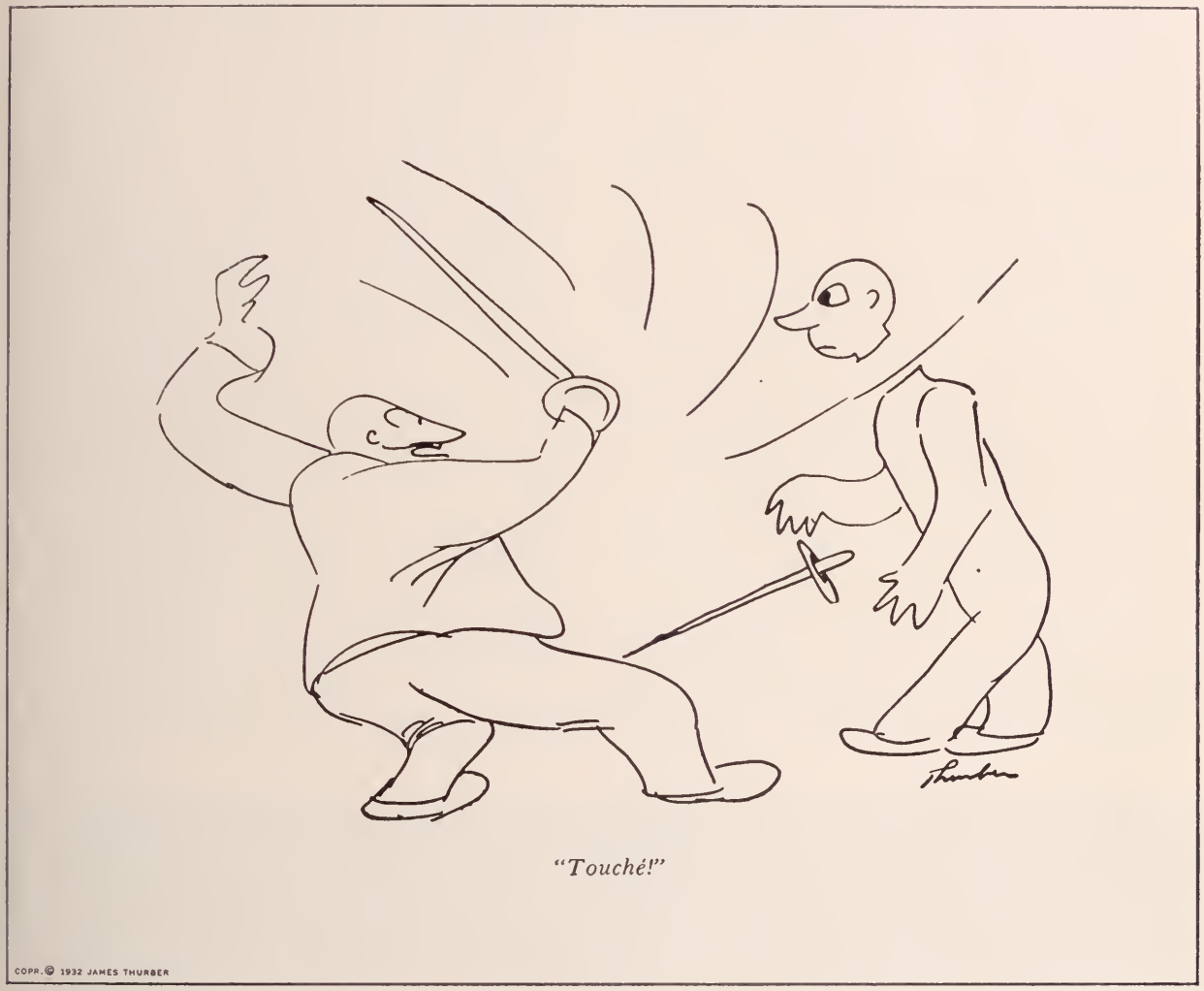
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For a better way to treat headache,
prescribe **Trancoprin**®.

How Trancoprin relieves pain: Because most pain is accompanied by muscle spasm and tension, good medical practice suggests use of an analgesic that will relax skeletal muscles as well as dim pain perception. Such an analgesic is Trancoprin — a combination of aspirin and Trancopal®, a proved, safe, skeletal muscle relaxant and tranquilizer. Trancoprin can be prescribed for any pain, except pain of such severity that a narcotic is needed.

Dosage: Adults, 2 tablets three or four times daily; children (5 to 12 years), 1 tablet three or four times daily. Each tablet contains 300 mg. of aspirin and 50 mg. of Trancopal (brand of chlormezanone). Bottles of 100 tablets.

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OBITUARIES

Herbert L. Bryans

Dr. Herbert L. Bryans of Pensacola died unexpectedly in that city on June 8, 1961. He was 71 years of age.

A native of Georgia, Dr. Bryans was born in Griffin on Sept. 16, 1889. He was the son of the late Dr. Robert L. Bryans. Since early childhood he had resided in Pensacola where he attended public schools and the Pensacola Classical School. He received his medical training at Emory University School of Medicine (Atlanta College of Physicians and Surgeons) and was graduated in 1911. The following year he spent in postgraduate study at the New York Post-Graduate Medical School and Hospital.

In 1913 Dr. Bryans entered the private practice of medicine in Pensacola. With the advent of World War I, he was commissioned as a first lieutenant in the Medical Reserve Corps of the United States Army and, until his discharge as major in 1919, he was on detached duty with the British Royal Army Medical Corps in England, Belgium and France. He then accepted a position with the United States Veterans Bureau in Washington as an associate member of the Board of Appeals and later was assigned to the New Orleans office as chief of the medical rating section. In 1923 he resigned and returned to Pensacola to resume private practice.

Locally, this distinguished internist had served as Chief of Staff at the Sacred Heart Hospital and was the first Chief of Staff at the Baptist Hospital. He worked diligently to secure the Escambia General Hospital and helped to establish the Escambia County Health Department. Through his efforts the first school for practical nurses in the state was established at the Pensacola Vocational School, and he then aided the establishment of other such schools throughout the state. From the time of its formation, he served as a member of the Advisory Council to the Pensacola Junior College School of Nursing. At the time of his demise he was a school trustee and had been for many years. He held membership in and was a past president of the Rotary

1 2 3 4
clinical studies repeat...

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Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.
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1 "significant hearing improvement" occurred with Arlidin in 32 of 75 patients with recent onset hearing impairment due to labyrinthine artery ischemia.
Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

3 Arlidin "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.
Seymour, J. C.: Laryngology & Otology 74:133, 1960.

Club, was a thirty-second degree Mason, was a life member and the first monarch of the Zelica Grotto, was a member of the Pensacola Country Club, and was an active and devoted member of the Gadsden Street Methodist Church.

Dr. Bryans served the Escambia County Medical Society in many capacities and was a past president. That society awarded him a certificate of merit in 1961 for his outstanding work in the field of Nursing Education Promotion. He was a founder of the Gulf Coast Clinical Society and at one time served as its president. The founder of the Northwest Florida Academy of Internal Medicine, he became its first president. He was a director of the Escambia County Blood Bank and had served on the board of the Escambia County Tuberculosis Association.

A life member of the Florida Medical Association, Dr. Bryans held many important posts during the 44 years of his membership. He had not missed a meeting of the Association since 1925 and was active on several important committees. In 1935 he served as president. For many years he was a member of the Board of Governors and for a number of years he represented the Association in the House of Delegates of the American Medical Association.

In addition to holding membership in the American Medical Association, Dr. Bryans was a diplomate of the American Board of Internal Medicine. He was also a fellow of the American College of Physicians. He was a charter member of the Rho chapter of the Theta Psi medical fraternity.

From 1941 to 1957, a period covering 16 of the 17 years of his membership on the Florida State Board of Health, Dr. Bryans rendered distinguished service as its president. His tenure of office was the longest in the history of that organization, and he gave unstintingly of his time for matters relating to public service, not missing a single formal meeting of that body.

Dr. Bryans had a keen interest in rehabilitation and assisted the Florida Vocational Rehabilitation Service in the establishment of medical standards for the state as a whole. In 1944, he became the first chairman of the Medical Advisory Committee, providing leadership in the development of a more comprehensive rehabilitation program. From 1950 to 1961 he was the District

vascular insufficiency
of the labyrinth is an important
etiologic factor in sudden
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of considerable value."

Wilmot, T. J. and Seymour, J. C.:
Lancet 1:098, 1960.

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Wilmot, T. J.: J. Laryngology &
Otology 73:466, 1959.

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Sheehy, J. L.: Laryngoscope 70:885, 1960.

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Medical Consultant for the Pensacola Office of Vocational Rehabilitation. In addition, he was a member of the Crippled Children's Commission for many years.

Surviving are the widow, Mrs. Edna Mae Snyder Bryans, and a son, Robert Lee Bryans II, both of Pensacola; and a sister, Mrs. Paul Mathison, of Montgomery, Ala.

NEW MEMBERS

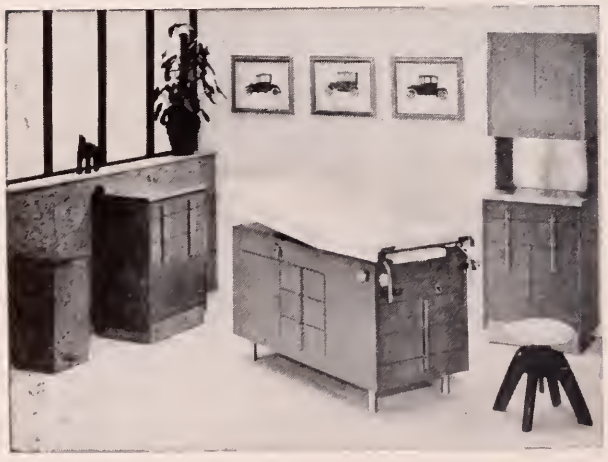
The following doctors have joined the State Association through their respective county medical societies.

Active

Albritton, David C., Ocala
Babcock, Roy H., St. Petersburg
Brokaw, Bergon F., Leesburg
Cross, John D., Bunnell
Daniel, Thomas M., Avon Park
Eissman, Robert C., Lakeland
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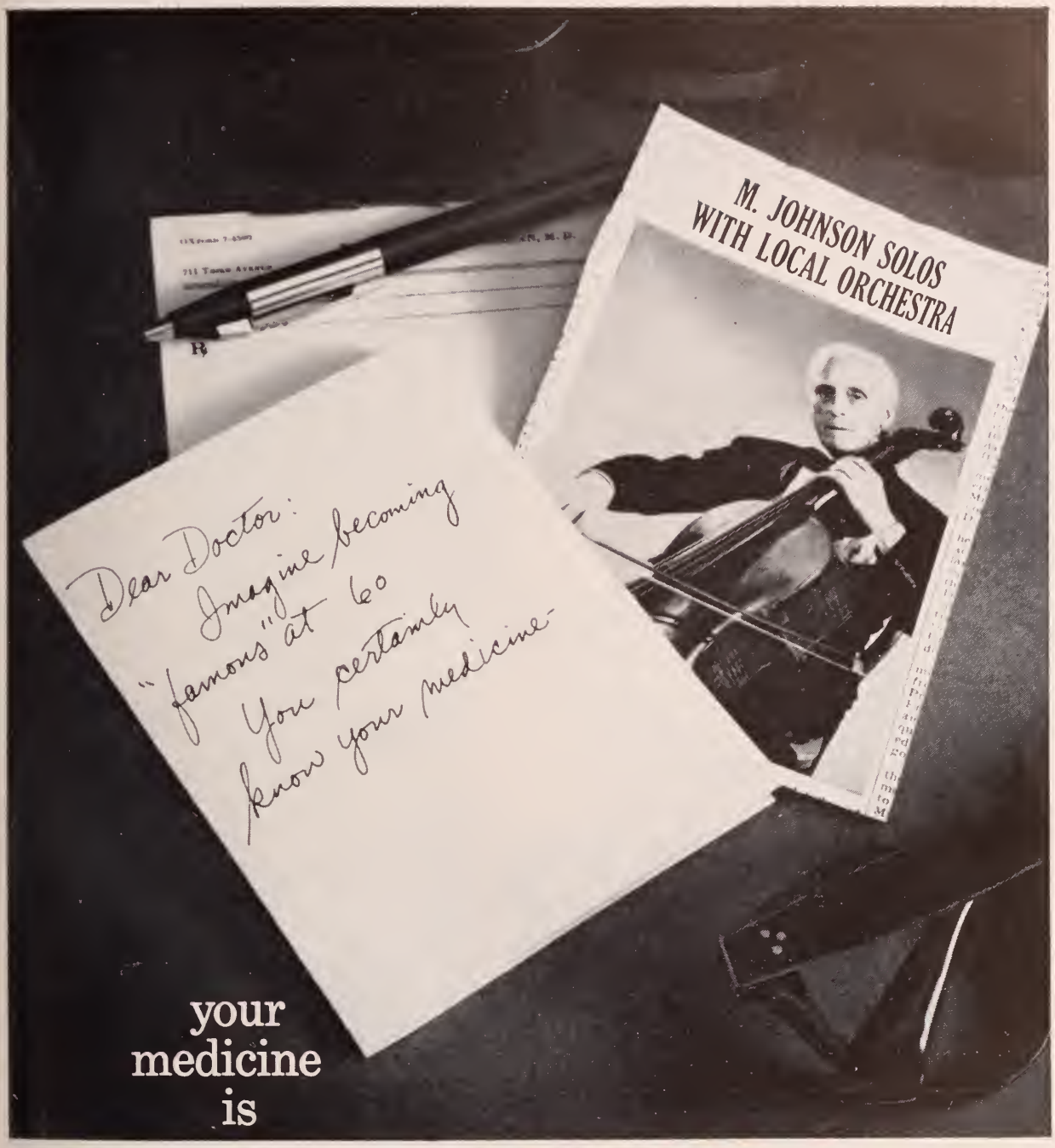
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(Continued on Page 202)



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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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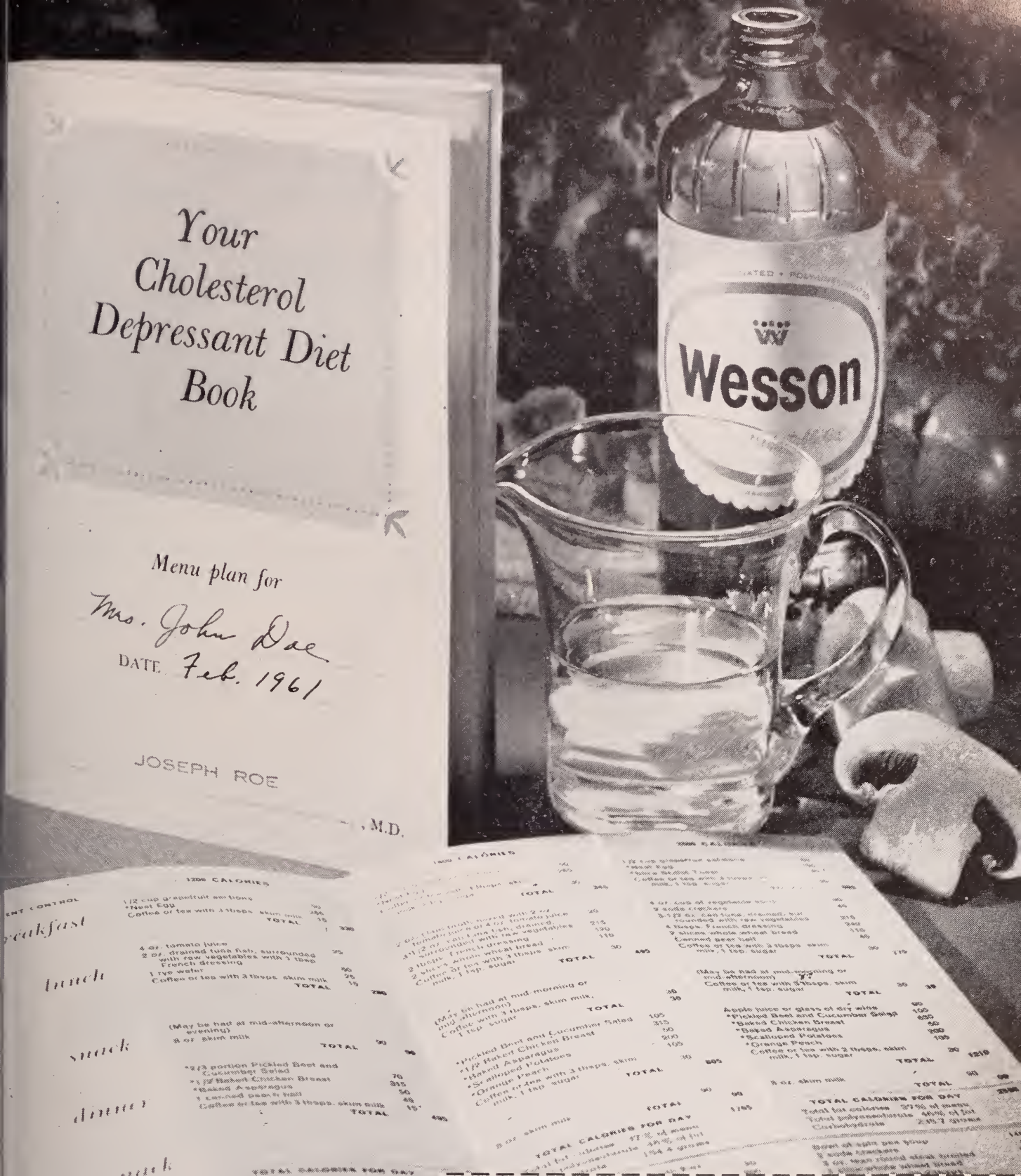
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BOOK REVIEWS

Your Heart: *A Handbook for Laymen.* By H. M. Marvin, M.D. Pp. 335. Price $4.50. Garden City, N.Y., Doubleday & Company, Inc., 1960.

This volume, written by a past president of the American Heart Association, discusses the various types of heart disease in lay terminology. It attempts to answer the most frequently asked questions about heart disease in a way that the layman of average intelligence cannot mistake. Chapters are devoted to the anatomy of the heart and blood vessels, irregularities of the heart beat, rheumatic heart disease, hypertension, congestive heart failure, angina pectoris, myocardial infarction, the pathogenesis of atherosclerosis, and other topics such as anticoagulants, stress and strain, congenital heart disease, neurocirculatory asthenia, obesity, smoking, and the heart and electrocardiogram.

The author writes well and quotes extensively from the medical literature and his personal experience of years of practice in the field of cardiology. The criticisms that seem evident to this reviewer are that the author has become too detailed in some sections such as that on arrhythmias and electrocardiography and that he has been too detailed in his accounts of the results in various studies. It is inconceivable that the majority of laymen will enjoy or profit from so much detail. On the other hand, the chapter on Patients and Doctors seems to be an eloquent contribution toward better public relations for the medical profession.

William M. Straight, M.D.

A Practical Guide for General Surgical Management. By Julian A. Sterling, M.D., Sc.D. Pp. 67. Price, $3.00. New York, Vantage Press, 1960.

There comes a time in the life of nearly every teacher when he experiences the urge to publish a book. The author of this text unfortunately selected a most inopportune era. The material presented here was well known by the first year surgical resident in Halsted's days. Chiefs of Surgery in teaching hospitals present guides of instructions to their resident staffs, many which are typewritten and nearly identical to the contents of this book. Many of the pages in this binding are superfluous. This outline could have been reduced in size with the pages stapled together and sold for one-sixth the price for which it is offered. The book contains the general policy of a given hospital in regard to its procedure in the care of a surgical patient. The last of its four sections summarizes laboratory values which may be found on wards in all modern hospitals. The author has published many better articles, and this compend certainly does not add to his prestige.

Clifford C. Snyder, M.D.

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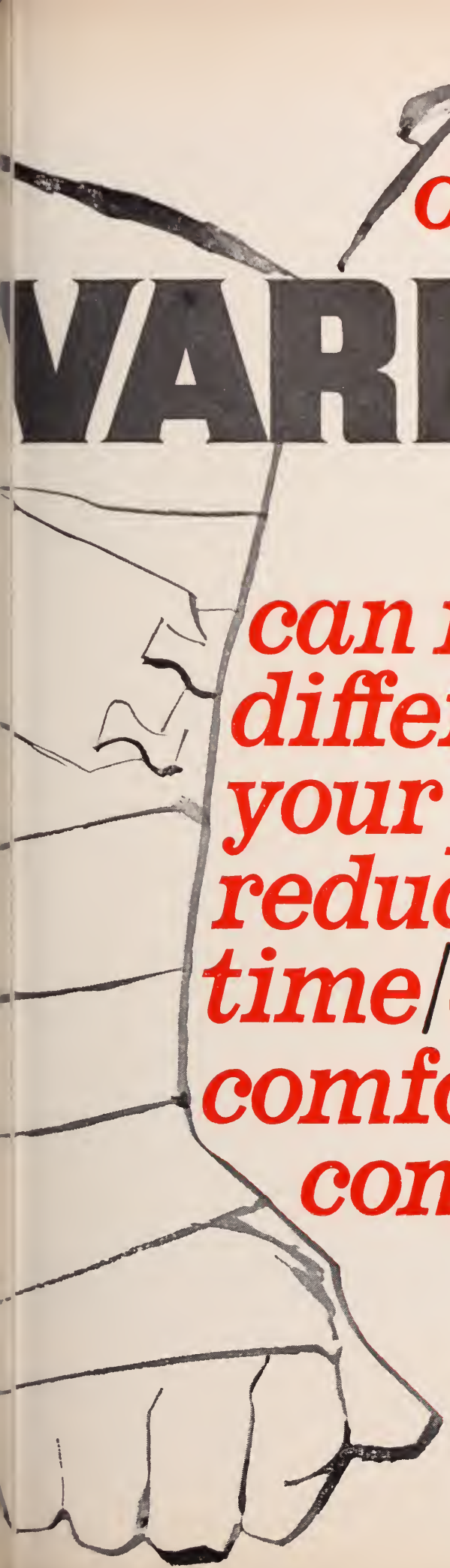
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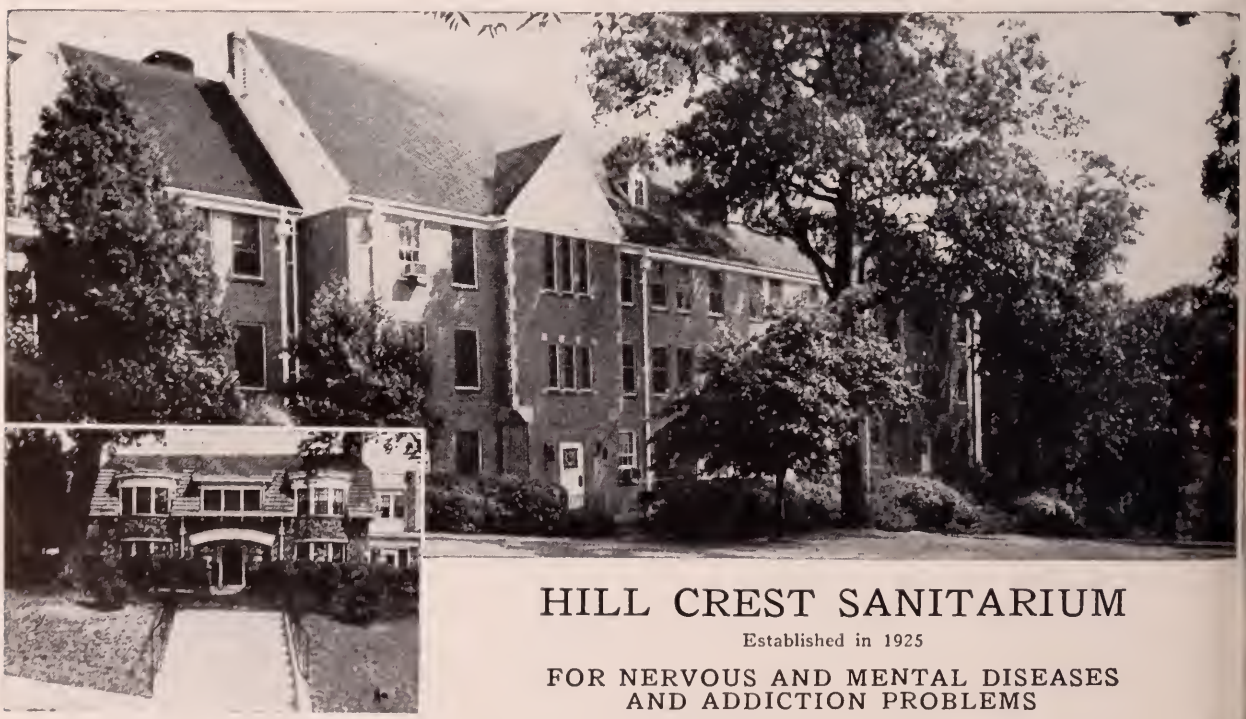
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Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T. C. C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition. W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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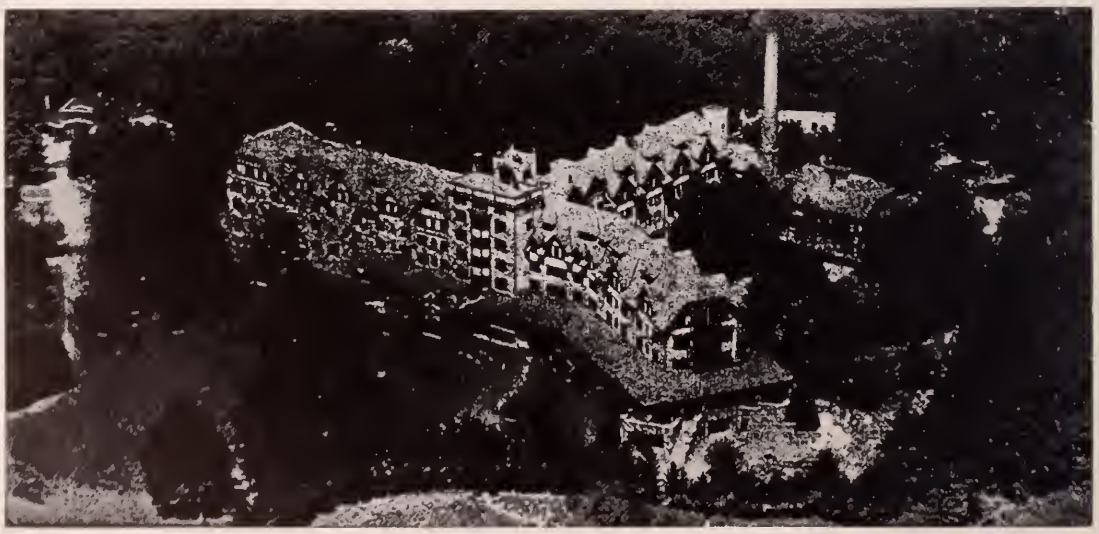
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Hospital Association	Joseph F. McAloon, Hollywood	J. A. McDonald, Apalachicola	Jacksonville, Nov. 16-
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A.M.A. Clinical Session			Denver, Nov. 27-30,
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S.E. Am. Urological Assn.	A. D. Mason Jr., Memphis	L. C. Roberts, Durham, N. C.	Clearwater, March 19
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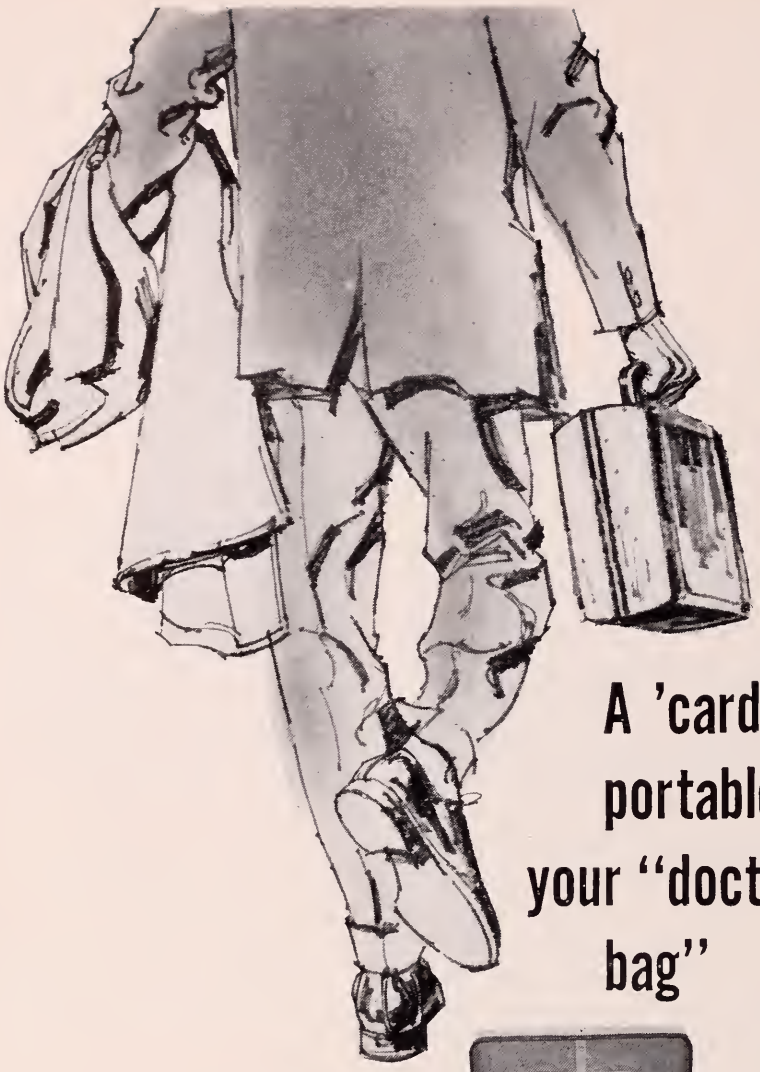
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* *Baker*				
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supplied: Pink tablets, 3.6 mg., bottles of 100.

references: (1) Lish, P. M.; Albert, J. R.; Peters, E. L., and Allen, L. E.: Arch. internat. pharmacodyn. *129*:77-107 (Dec.) 1960. (2) Howell, C. M., Jr.: North Carolina M. J. *21*:194-195 (May) 1960. (3) Clinical Research Division, Mead Johnson & Company. (4) Wahner, H. W., and Peters, G. A.: Proc. Staff Meet. Mayo Clin. *35*:161-169 (March 30) 1960. (5) Crepea, S. B.: J. Allergy *31*:283-285 (May-June) 1960. (6) Crawford, L. V., and Grogan, F. T.: J. Tennessee M. A. *53*:307-310 (July) 1960. (7) Spoto, A. P., Jr., and Sicker, H. O.: Ann. Allergy *18*:761-764 (July) 1960. (8) Arbesman, C. E., and Ehrenreich, R.: New York J. Med. *61*:219-229 (Jan. 15) 1961.

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(1) Carter, S.: *M. Clin. North America* 37:315, 1953.
(2) Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.
(3) Buchthal, F.; Svensmark, O., & Schiller, P. J.: *Arch. Neurol.* 2:624, 1960.

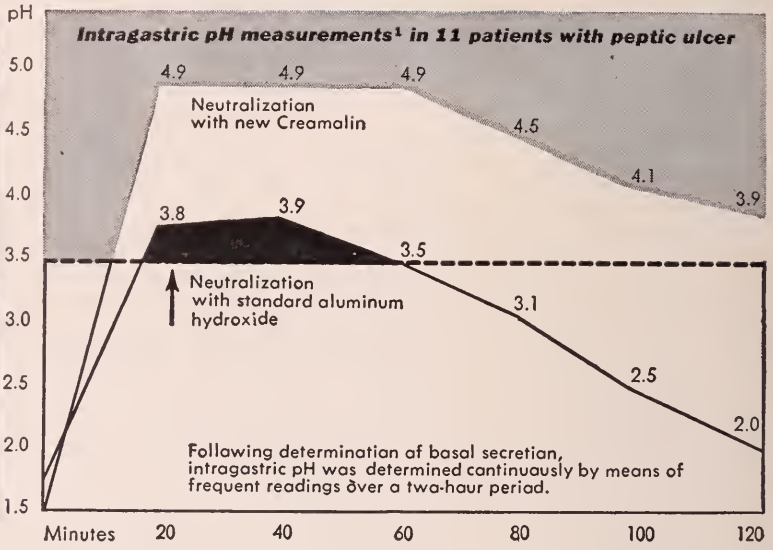
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References: 1. Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. 2. Beckman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. 3. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. 4. Data in the files of the Department of Medical Research, Winthrop Laboratories. 5. Hinkel, E. T., Jr. ; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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VOLUME XLVIII, No. 3

• *September. 1961*

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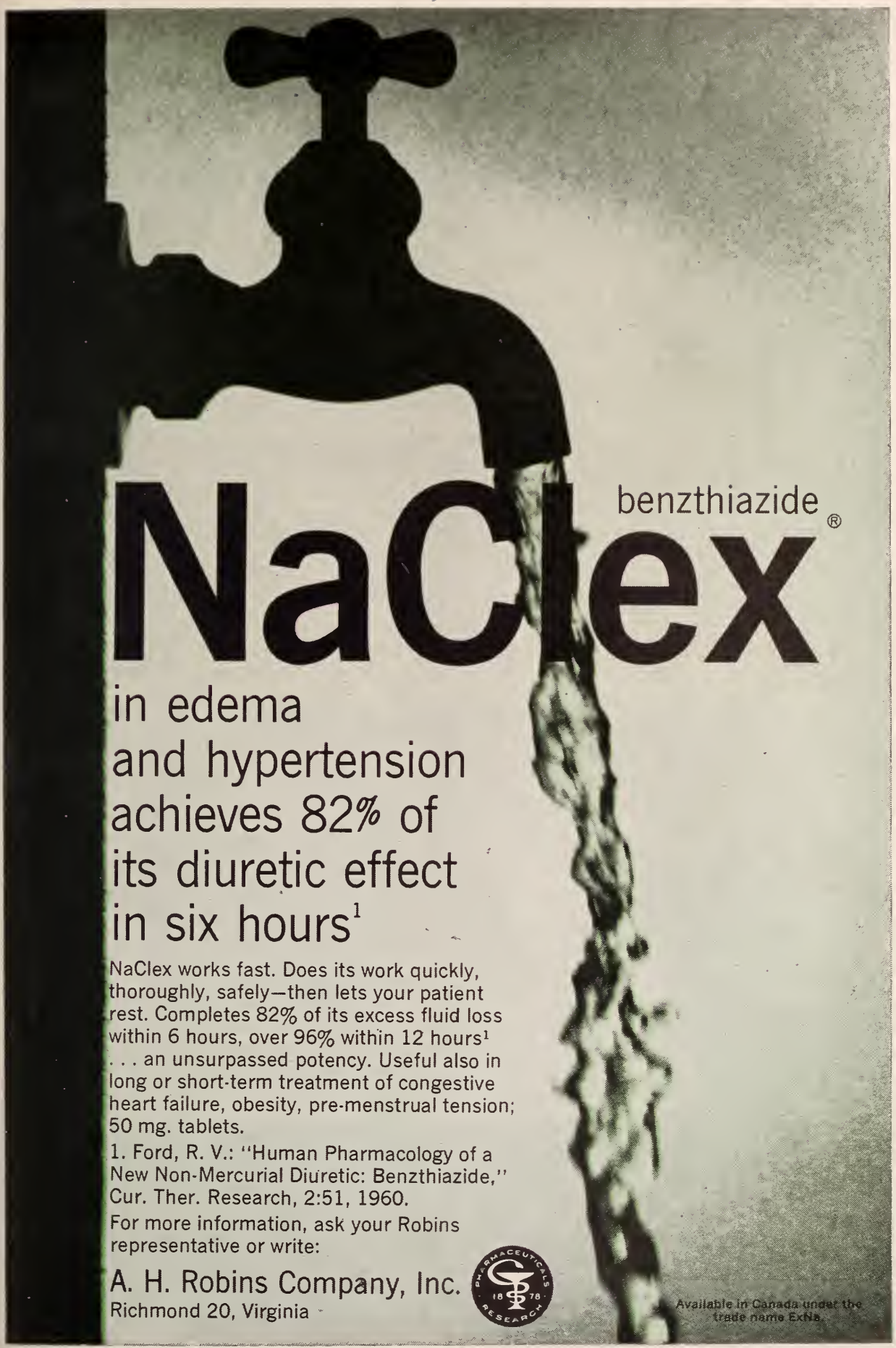
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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*Gant, J. Q., Jr.: *M. Ann. District of Columbia* 30:267, 1961.

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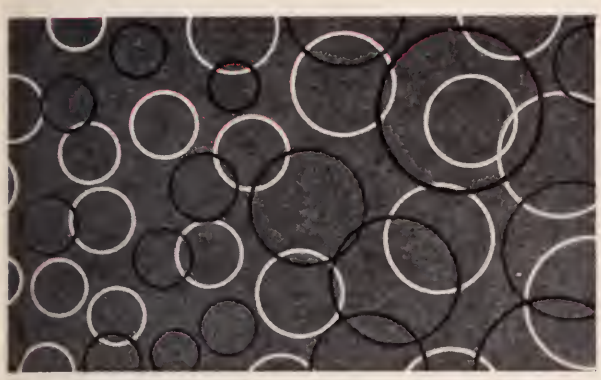
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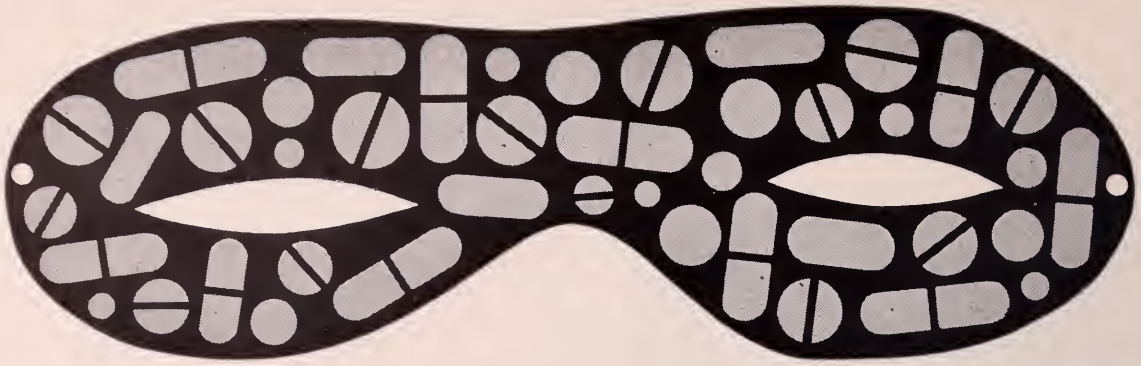
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Rhode Island Medical Journal,
January, 1961

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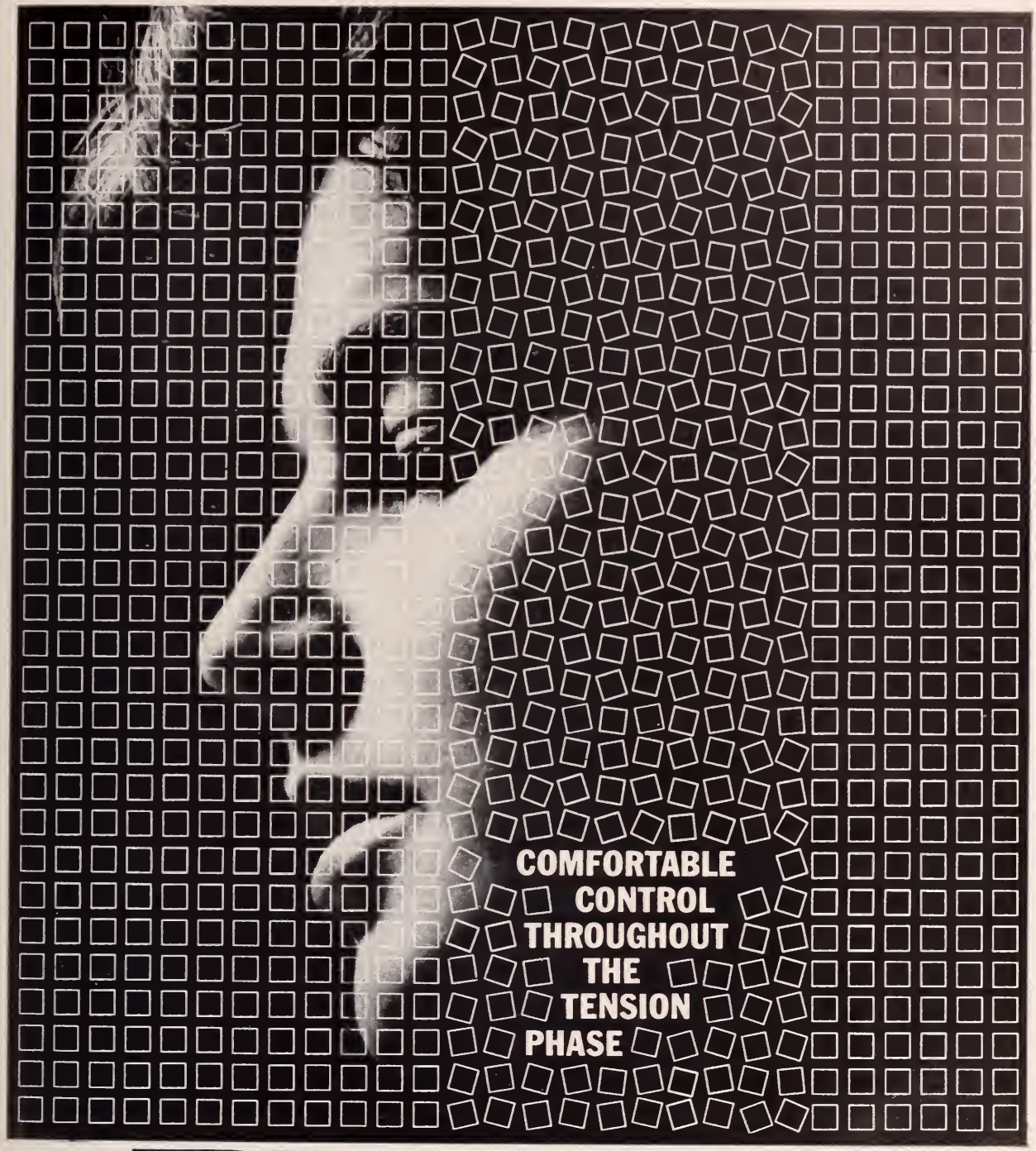
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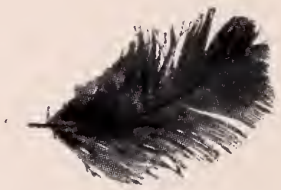
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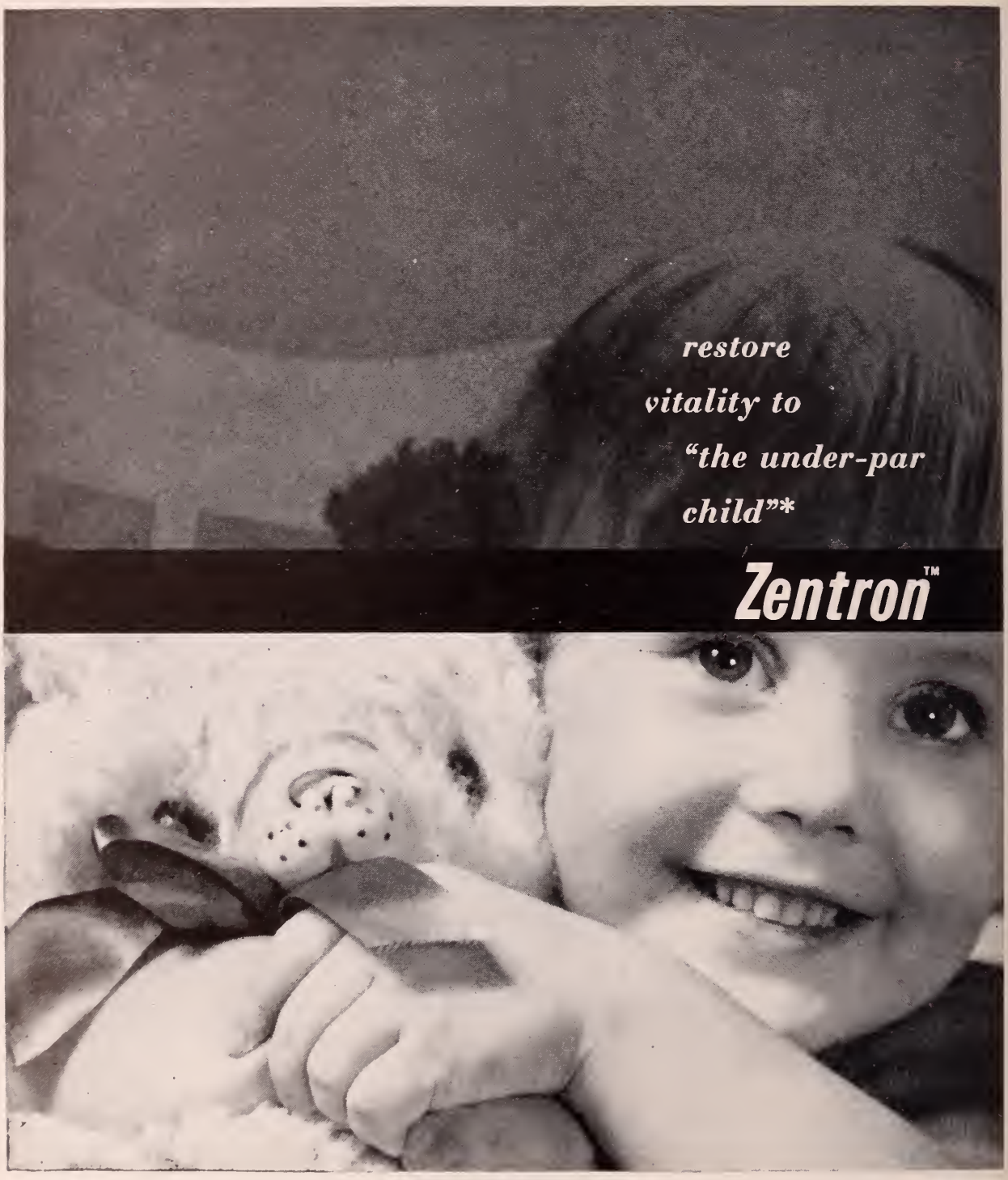
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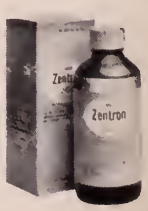
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The Hepatic Circulation and the Pathogenesis of Portal Hypertension

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The increased interest in diseases of the liver and their sequelae is justified in this "ever shrinking world." Geopathologists indicate that, on a worldwide basis, the liver is more frequently involved in carcinoma than any other organ[1] and, in certain parts of Africa, cirrhosis has been reported in four out of five autopsies.[2] In this country cirrhosis of the liver has become one of the 10 leading causes of death with only heart disease, cancer, and cerebral hemorrhage in the age group between 45 and 64 outranking it.[3]

In approximately 60 per cent of patients with histologically proved cirrhosis esophageal varices develop.[4] Serious hemorrhage secondary to esophageal varices occurs in 25 to 30 per cent of cirrhotic patients.[4,5] Recently it has been estimated that one patient out of three who enters the hospital with massive upper intestinal hemorrhage is bleeding from varices (from all causes).[6]

Esophageal varices, for all practical purposes, are secondary to alterations in pressure within the portal venous system, that is, portal hypertension. While it is true and properly taught that portal hypertension is related to cirrhosis of the liver, until proved otherwise, the etiological aspects of portal hypertension unrelated or indirectly related to cirrhosis deserve greater attention. This broader concept of portal hypertension, however, cannot adequately be discussed without first presenting some of the exciting newer developments in the study of the liver cell and the hepatic vascular anatomy.

As determined by studies with the electron microscope and histochemistry, the surface of the hepatic cell has several degrees of activity; it is triphasic.[7] That portion of the cell membrane which is adjacent to other liver cells is the least active. The second surface is somewhat more active and its specialization is indicated by the presence of microvilli. This actually is the bile canaliculus. The third surface, and the most active, is also composed of microvilli. This is the portion of the cell membrane which is adjacent to the sinusoids. A layer of Kupffer cells is found between the actual microvilli and the sinusoidal lining. The microvilli have been demonstrated by utilizing the electron microscope. The activity of the cell membrane has been demonstrated in histochemical studies in which enzyme systems are precipitated out by various means.[8] The amount of precipitate is an indication of the activity of the enzyme. Davis, Morse, Larsen and Wynn[9] recognized the potential clinical use of intracellular hepatic enzyme systems several years ago.

To Elias[10] must go the credit for the recent interest in the histology of the liver. Ultramicroscopic techniques have served to enhance the significance of his meticulous work. This is the key to the understanding of microscopic liver anatomy. We will concern ourselves with the vascular aspects only.

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From the Portal Vein to the Sinusoid

The portal vein enters the liver at the porta hepatis and helps form the portal tract. The liver lobule is entered by means of "inlet veins" which pierce the "limiting plate"—the outer rim of cells of the lobule. The inlet veins are supplied with a sphincter-like mechanism and the sinusoids themselves are contractile so that blood passing from the inlet vein to the sinusoid takes a circuitous course. As indicated previously, there are also outlet sphincters at the junction of the sinusoids and central veins. In the normal liver there is no communication between the portal vein and the central vein except through the sinusoids.

From the Sinusoid to the Hepatic Vein

Individual sinusoids enter—each by itself—into the central vein. There is no direct drainage from the sinusoid into the larger radicals of the hepatic vein as in the rabbit, the rat, and the dog. Thus there is a bottleneck of drainage in man which is aggravated by the existence of potential constriction around the mouths of the central veins. In many species there are sphincters along the entire course of the hepatic vein. They are prominent in the dog. They have no apparent function—except to cause hypotension. Dogs, therefore, are basically not suitable animals for blood pressure experiments since anesthesia affects these sphincters.

From the central vein in man venous blood enters the sublobular vein and thence is carried to the larger hepatic veins and ultimately to the supradiaphragmatic inferior vena cava.

The Hepatic Artery

The extrahepatic treachery of the hepatic artery is well known to surgeons. One investigator reports as many as 43 per cent of all specimens having more than one hepatic artery.[11] It enters the liver at the porta hepatis and supplies the structures of the portal canals through a capillary network.[12] There is more than usual controversy regarding its terminal portion. Apparently it enters the portal vein at the level of the inlet vein although it may also pierce the limiting plate and directly anastomose with the sinusoid. At the terminal portion of the hepatic artery there is a sphincter-like mechanism. A nerve plexus has been demonstrated at this point.

There are no arterial anastomoses between territories supplied by branches of the hepatic artery. They are, in effect, end arteries. Ligation of any artery, however small, which enters the liver will result in an anemic infarct. Antibiotics, in man, will not prevent this anemic infarct from developing. Only ligation in the vicinity of the celiac axis, in the area of extrahepatic collateral circulation, will have no ill effects.

Broadly defined, portal hypertension is an alteration in the resistance to blood flow within the portal system. It is not only the result of various obstructive phenomena at various levels but also basic changes within the circulation itself. Table 1 is a summary of these changes as well as a classification of the etiological factors involved in the production of portal hypertension. It seemed most logical to divide these factors into three categories: suprahepatic, hepatic, and infrahepatic.[13] Factors which are suprahepatic in location are those conditions which cause alteration in resistance within the portal system which are located above or cephalad to the liver.

The causes of suprahepatic hypertension are thromboses—acute or chronic—of the inferior vena cava above the level of the liver, that is, above the diaphragm. Of the cardiac causes tricuspid incompetence and constrictive pericarditis are the most important. Congestive heart failure, per se, rarely will exist for a long enough period to cause irreversible intractable portal hypertension.

The intrahepatic or hepatic etiological factors in alteration of resistance within the portal system

Table 1.—Summary of Basic Circulatory Changes and Classification of Etiological Factors Involved in Production of Portal Hypertension

A. Suprahepatic
  1. Cardiac
    a. Constrictive pericarditis
    b. Tricuspid insufficiency
    c. Congestive heart failure (?)
  2. Thrombosis of the inferior vena cava (supra-diaphragmatic)

B. Hepatic
  1. Cirrhosis
    a. Post(supra)sinusoidal
      (1) Constricting lobule
      (2) Fibrosis of the portal tract
    b. Parasinusoidal
      (1) Venovenous shunts
      (2) Fibrosis of the portal tract
    c. Pre(infra)sinusoidal
      (1) Arteriovenous shunts
      (2) Fibrosis of the portal tract
  2. Schistosomiasis

C. Infrahepatic
  1. Intrinsic lesion of the portal vein
    a. Acute thrombosis
    b. Chronic thrombosis
    c. Cavernous transformation of the portal vein
    d. Septic involvement of the umbilical vein
  2. Extrinsic (pressure on the portal vein)
    a. Carcinoma of the pancreas
    b. Massive adenopathy, et cetera

include cirrhosis and schistosomiasis. "Cirrhosis" is a generic term and is here defined as a progressive disease of the liver with morphologic manifestations described below and in table 1, irrespective of etiology. The morphologic changes within the liver constitute an important factor in the alterations of the intrahepatic vascular system and thus are, in part, responsible for alterations in resistance within the portal system. The liver itself may be subdivided into post(supra)sinusoidal, parasinusoidal and pre(infra)sinusoidal. The postsinusoidal area is the same as the "outflow tract" of Madden, Lore, Gerold and Ravid.[14] The presinusoidal area is, of course, the "inflow tract."

In the postsinusoidal area portal hypertension is due to compression of the hepatic veins by connective tissue proliferation and the compression of the portal tract area by the growing regenerating lobules. This latter, the compression of the portal tracts, is a most important factor.

In the parasinusoidal area there are venovenous shunts between the portal and hepatic veins bypassing the liver parenchyma. Please recall that in the normal liver there are no direct communications between the portal and hepatic veins, except through the sinusoids.

In the presinusoidal area there are arteriovenous shunts between the portal vein and the hepatic artery. The hepatic artery in the normal liver enters the lobule at the level of the inlet vein or the sinusoid. In effect, the venovenous shunts and the arteriovenous shunts cause the liver parenchyma to be bypassed. In all areas whether postsinusoidal, parasinusoidal, or presinusoidal the fibrosis within the portal tract is an important factor in producing increased portal pressure.

The overwhelming number of patients with portal hypertension will be cirrhotic patients, as indicated previously. In a consideration of the intrahepatic factors, however, schistosomiasis has assumed increasing importance and will probably assume even more prominence in the future. Schistosoma mansoni is endemic in Puerto Rico and the Caribbean area in general, and in some areas of South America, notably Northern Brazil and Venezuela. The ova are carried by snails which are found in waterways in which bathing and washing take place. The skin is penetrated directly, and ova are carried to the portal vein where a periphlebitis with fibrosis of the portal tract takes place. The compression of the portal vein in the portal tracts is a result of this fibrosis. The alteration in resistance takes place at the presinusoidal level within the liver (intrahepatic). In this disease ascites and liver failure are rare. There are minimal changes on liver function studies. Thus in a young man from the Caribbean area, or of South American origin, who presents with gastrointestinal hemorrhage, the diagnosis of schistosomiasis should be considered with the origin of the bleeding from esophageal varices secondary to portal hypertension. The diagnosis can often be made by biopsy of the valves of Houston and finding the laterally spined ova.

The third group of etiological factors concerned with the production of alteration in resistance within the portal system is extrahepatic and located below or caudad to the liver (infrahepatic). In general, these factors are intrinsic or extrinsic with reference to the portal vein. The intrinsic factors are those which directly involve the lumen of the portal vein, and, as indicated in table 1, consist of acute and chronic thrombosis, cavernous transformation of the portal vein—which actually is a recanalization of a previous thrombus—and septic involvement of the umbilical vein in infancy. The extrinsic etiological factors are those concerned with pressure from without, on the portal vein, as carcinoma of the pancreas.

The Measurement of Alterations of Resistance Within the Portal System

Both as an experimental and clinical tool the wedge hepatic venous pressure has shown great promise.[15,16] This procedure involves catheterization of the antecubital vein, through the right side of the heart to the inferior vena cava and hepatic vein. The catheter is wedged in the periphery of the liver, in a sinusoid. The measurement obtained is the same as the intrasinusoidal pressure in most cases and normally its upper limits are 10.5 to 11 mm. of mercury. The highest recorded portal pressure is in the neighborhood of 45 mm. of mercury.[17]

Alterations in portal tension can also be detected by utilizing percutaneous splenoportography and splenic pulp pressure.[18,19] In some parts of the country these procedures are used almost routinely in problems involving the etiology of upper gastrointestinal hemorrhage, evaluation of the portal system prior to surgical correction of portal hypertension, and postoperatively for long term evaluation of the efficacy of the procedure itself in reducing pressure and in determining patency of shunts.

A practical approximation of portal tension can be obtained with a lumbar puncture tray, by utilizing the manometer and a needle in a vein within the portal system. The venipuncture can be accomplished during celiotomy in a vein which drains into the portal vein. A somewhat less accurate approximation can be obtained by venipuncture of a dilated abdominal wall vein. With this type of water manometer portal hypertension exists when the pressure is greater than 250 mm.

Summary

A classification of the etiologic factors involved in the production of portal hypertension is presented. The increased incidence of noncirrhotic factors is stressed. Reference is made to newer experimental and clinical tools. The hepatic vascular system is reviewed.

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Abdominal Pain Associated With "Milk of Calcium Bile"

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Judging from the paucity of clinical reports revealed by a perusal of the literature, a brief review of the clinical entity here presented is justified because of the possibility of error that may result in diagnosis owing to a lack of familiarity with the condition. The occurrence of this curious deposition of lime salts within the gallbladder wall and in the gallbladder lumen is relatively rare.

The first case report was published in this country in 1911 by Churchman,[1] who found a material in the gallbladder having the consistency of toothpaste. Two cases were reported in the European literature in 1926 by Volkmann,[2] and he used the term "Kalkmilchgalle" or "milk of calcium bile." The report of Phemister, Rewbridge and Rudisill[3] suggested that cystic duct obstruction by stone, inflammation or tumor may be the cause of precipitation of calcium carbonate in the gallbladder bile. This milk of calcium bile can thereafter adhere on already existing gallstones of the cholesterol-calcium-bile pigment varieties, which are common, or it may per se precipitate out as a stone or a semifluid to pasty mass. The present case represents a probable early case of Kalkmilchgalle in the chalky gravel stage since no hypertrophy of the muscularis of the gallbladder, found in long-standing cases, was present.[4,5]

The manifestations of this entity do not differ from those of other types of cholelithiasis with

the usual clinical course and complications. In the majority of reported cases, the history was that of chronic recurring and usually mild episodes of biliary colic.

Diagnosis, preoperatively, is possible only by roentgen ray study. Occasionally, on a plain film, a shadow or shadows of calcium density may be visible in the region of the gallbladder. The density varies depending upon the calcium content. A suggestion of the presence of stones in the cystic duct, as evidenced by radiopaque circular densities, may be a concomitant finding. In this particular case, the calcium bile did not completely fill the lumen of the gallbladder, but was evident as a crescent-shaped opacity in the dependent portion of the gallbladder. Note that with the patient in the standing position, such a crescent-shaped density is seen in the dependent aspect of the gallbladder lumen (fig. 1). With the patient in the decubitus position, this opacity is seen to shift to a dependent position (fig. 2). No densities resembling calculi in the cystic duct are seen in either of these two films. Occasionally, the particular gallbladder dye has been administered before any roentgenographic examination has been performed and the limy bile will be missed. Suspicion, however, is often aroused by failure of the gallbladder shadow to change significantly in size following a fatty meal. This in itself is not pathognomonic. If such a suspicion of abnormality is entertained, the gallbladder should be subjected to roentgen examination again at a later date, particularly when either definite or questionable stone shadows are visualized in the region of the cystic duct.[6]



Fig. 1. — With the patient in the standing position, note the crescent-shaped density in the dependent aspect of the gallbladder lumen.



Fig. 2. — With the patient in the decubitus position, the opacity representing "milk of calcium bile" is seen to shift to a dependent position.

Report of Case

A 32 year old white man was admitted to a Tampa hospital on Dec. 12, 1959. Shortly before his condition was evaluated in the emergency room of this hospital, the patient was on a hunting trip and was seized with pain of sudden onset located high in the epigastrium. It seemed to spread laterally to each side at this level. The pain was described as being dull and moderately severe with five to 10 minute episodes of exacerbation of a cramplike character. It was not accompanied by nausea and vomiting, and there appeared to be no relationship to exercise. Slight relief was obtained by leaning forward, and the pain was of such a character that it apparently prevented deep breathing. The patient had had similar episodes of pain on five occasions since May. In May he was admitted to a Tampa hospital with a similar, moderately severe episode which lasted approximately 45 minutes. On this admission, a gastrointestinal series, cholecystogram, intravenous pyelogram and right retrograde pyelogram disclosed no significant abnormalities. There had been no history of qualitative food intolerance and no history of melena. At no time was there an elevation of temperature. The present episode was the most severe.

Past History.—The patient had an appendectomy in 1934 and a tonsillectomy in 1945. He had experienced frequent chalazions during the previous five years. There were no significant cardiorespiratory, gastrointestinal, or genitourinary symptoms other than those mentioned.

Family History.—Noncontributory.

Physical Examination.—When evaluated in the emergency room, the patient's condition was not remarkable except for definite tenderness under the midright costal margin.

Laboratory Findings.—A complete blood count, sedimentation rate, urinalysis, blood sugar, serum amylase, serum transaminase, and serologic examination all gave



Fig. 3. — Gallbladder removal at operation showing congested mucosal surface.



Fig. 4. — The wall of the gallbladder is thickened by an infiltration of chronic inflammatory elements and some interstitial fibrosis.

negative results. Total serum cholesterol was 226 mg. per hundred milliliters. Cholesterol esters were 168 mg. per hundred milliliters. A direct bilirubin test showed 0.45 mg. with a total of 1.38 mg. per hundred milliliters. An electrocardiogram was normal.

A gastrointestinal roentgen examination was not remarkable. A cholecystogram revealed that the gallbladder concentrated the opaque medium well. Milk of calcium bile was noted in the dependent portion of the gallbladder on the erect (fig. 1) as well as the decubitus views (fig. 2). A film taken after stimulation of the gallbladder with a fatty meal revealed no significant contraction.

After surgical consultation, a cholecystectomy was performed on December 17 by Dr. Leffie M. Carlton. The specimen (fig. 3) consisted of a gallbladder measuring 8 by 4 by 4 cm. The serosal surface was covered by a shaggy fibrous tissue. The lumen contained approximately 20 cc. of black bile. The cystic duct showed no gross obstruction. Sediment in the bile consisted of calcium carbonate. The mucosa was congested. The microscopic examination (fig. 4) disclosed that the wall of the gallbladder was thickened by an infiltration of chronic inflammatory elements and some interstitial fibrosis. The pathological diagnosis was chronic cholecystitis with calcium carbonate sediment in the bile.

The patient has remained asymptomatic.

Summary

A case of abdominal pain in a 32 year old white man is presented. The diagnosis of gallbladder disease was established on the basis of the clinical picture, exclusion of other possible causes of this type of pain, and especially the results of roentgen examination. This probably represented an early stage in the natural history of cholecystitis with so-called "milk of calcium bile."

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Anaphylactoid Reaction to Oranges

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A case of anaphylactoid reaction to an orange was reported by Bendersky and Lupas[1] in the Journal of the American Medical Association, May 21, 1960. It was stated that it was the first such case reported in the literature. This report concerns a similar case.

Report of Case

A 49 year old somewhat obese white woman was brought to my office at approximately 4 p.m. on Jan. 18, 1960 in acute respiratory distress. She had eaten only toast and black coffee for breakfast. She ate no lunch and ingested nothing until just before coming to my office. At that time she peeled and ate two Valencia oranges. Approximately 10 minutes later shortness of breath and marked generalized itching developed. She was brought immediately to my office. Physical examination revealed the patient, who was sitting on the end of the examining table, to be in marked distress. Respirations were deep and fast, approximately 40 per minute, with no wheezing. The blood pressure was 64/40 mm. Hg. The skin was generally erythematous with a few wheals visible on the back. Her face, hands and feet were edematous. She was scratching herself furiously. She was dizzy and collapsed on the office floor. The following medication was given immediately: adrenalin 1:1000, 0.6 cc. intramuscularly; Benadryl, 50 mg. intramuscularly; Wyamine, 30 mg. intravenously; and Acthar Gel, 80 units intramuscularly. The blood pressure rose to 84/64 mm. Hg after administration of the Wyamine, but the patient was not able to raise her head without getting dizzy. She was taken by ambulance to the hospital breathing oxygen and in the shock position.

She arrived at the hospital at 5:05 p.m., somewhat improved. The blood pressure was 138/70 mm. Hg, the temperature 96.4 F., the pulse rate 90, and respirations 32. Oxygen by tent and 1,000 cc. of 5 per cent glucose in normal saline with 100 mg. of Solu-cortef were given at 60 drops per minute. She received one Benadryl Kapseal every six hours, 30 cc. of castor oil immediately and other symptomatic therapy. Recovery continued rapidly. At 10:30 p.m. the blood pressure was 164/96 mm. Hg, the redness of the skin had subsided, and she was in no distress. The blood pressure has continued at about this level, and it has been concluded that she has mild hypertension.

The history revealed that the patient had collapsed in 1925 after taking an APC capsule. She thought the episode was similar to the present one. Mild constant edema of the face, hands and feet had been present for 30 years. She had experienced mild nasal stuffiness in damp weather for years. No allergic manifestations were present in the family. A detailed physical examination revealed the findings previously noted. The heart was normal with no evidence of left ventricular hypertrophy. Also there was some bogginess and a greyish hue to the nasal mucosa. It was concluded that allergic rhinitis and chronic angioneurotic edema were present.

The laboratory work was as follows: An electrocardiogram on January 18 gave evidence of left bundle branch block, and on the following day the pattern was even more typical. On roentgen examination of the chest, the left border of the heart and the aortic knob were somewhat more prominent than usual. The blood urea nitrogen was 12 mg., fasting blood sugar 93 mg., serum protein 5.7 Gm., albumin 3.8 Gm. and globulin 1.9 Gm. per hundred cubic centimeters, VDRL nonreactive, and serum glutamic oxaloacetic transaminase 8 units. A complete blood count showed a hemoglobin level of 14 Gm., white blood cell count 16,300, hematocrit reading 43, band forms 22 per cent, segmented forms 65 per cent, lymphocytes 12 per cent and monocytes 1 per cent. On urinalysis, the specific gravity was 1.013; albumin and sugar were negative; and on microscopic examination a few hyaline and fine granular casts were present. On January 20 an electrocardiogram indicated reversion from left bundle branch block to normal conduction through the ventricles and no abnormalities. The serum glutamic oxaloacetic transaminase was 0 units, protein-bound iodine 4.1 mg. and cephalin flocculation negative.

The patient was given Peritrate, 20 mg. four times daily because of the acute left bundle branch block. The bundle branch block was thought to be entirely a manifestation of the anaphylactoid shock. There was no evidence at any time of heart disease except for the suggestion of hypertrophy on the roentgenogram. The physical examination failed to reveal any evidence of paradoxical splitting of the second sound during the period of hospitalization.

The patient was discharged on January 21, three days after admission, in good condition.

Comment

This patient did not eat oranges frequently, but had eaten them in the past with no difficulty. Eating two oranges rapidly on an entirely empty stomach with rapid absorption might be a possible factor. Ratner and his associates[2,3] showed there are two distinct allergens in oranges. One is present in the seed and one in the juice itself. The one in the seed gives the more severe reaction.

Summary

A case is presented of an anaphylactoid reaction following the ingestion of oranges. This is the second such case reported. A left bundle branch block persisted for three days after this reaction.

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Pulmonary Embolism

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Recognition of the relationship of pulmonary embolism to venous thrombosis of the lower extremities is credited to Virchow around 1850. Since that time pulmonary embolism has come to be recognized as a lethal postoperative complication which has not decreased in incidence with the use of antibiotics, early ambulation, elastic support to the legs, or postoperative use of subtherapeutic doses of anticoagulant drugs. The clinician who has been confronted with a suddenly desperately ill patient, who a few moments before was apparently doing well, realizes the severity of the problem. As in most diseases of undetermined etiology, the treatment of venous thromboembolism has been empiric, the results varied, and the statistics difficult to evaluate.

Clinical Data

During a seven year period, 600 patients with venous thrombosis and 60 with pulmonary embolism were seen on the surgical, obstetrical and gynecological services at the Duke University Medical Center. The care and therapeutic evaluation of these patients form the basis of this review.[1]

Incidence and Etiology

As alertness to the possibility of pulmonary embolism is an essential part of one's diagnostic armamentarium, it is well to note when and where to expect this occurrence. Barker, Nygaard, Walters and Priestly[2] at the Mayo Clinic tabulated the frequency of pulmonary embolism after 172,888 operations. It was found to occur in 0.52 per cent of all operations; 3.32 per cent of splenectomies; 2.41 per cent of all intestinal resections; 2.18 per cent of all other intestinal operations, and 1.52 per cent of all hysterectomies.

Ochsner, DeBakey, DeCamp and da Rocha[3] reported postoperative embolism in 0.05 per cent of 647,868 operations.

From experience it would seem that one must anticipate venous thrombosis in the following types of cases: (1) a previous history of embolism; (2) extensive varicosities of the legs; (3) congestive heart failure; (4) extensive pulmonary or abdominal surgery; (5) obesity; (6) patients over 50 years of age; (7) extensive trauma to the legs; (8) immobilization; and (9) polycythemia vera.

Intimal damage, stasis, and hypercoagulability are usually implicated as etiological factors in venous thrombosis. In our experience, intimal damage and stasis appear to play a relatively minor role in the development of deep venous thrombosis though the true cause probably lies within the realm of these three factors. Thrombosis of the deep venous system of the legs occasionally develops after the prolonged use of an intravenous catheter in the long saphenous vein, thus giving support to the intimal trauma theory. The routine use of 10 mg. of heparin sodium in each liter of fluid administered by this route has been of definite benefit in minimizing superficial and deep venous thrombosis without an appreciable effect on the clotting time. The intravenous administration of fluid in the lower extremities should be avoided whenever possible to decrease the possibility of intimal damage.

Stasis due to immobilization and bed rest has been incriminated; however, early ambulation has not lowered the incidence of postoperative thromboembolism. Pulmonary embolism has not been recorded as a major complication among tuberculosis patients who have been at bed rest for long periods.

Hypercoagulability is a nebulous phenomenon that has been recognized by surgeons and physiologists to occur after trauma or surgical operations. There is no available laboratory measure of hypercoagulability which will detect the presence of excess amounts of specific blood clotting factors which may give rise to venous thrombosis and embolism. An, as yet, immeasurable hypercoagulability state remains an attractive theory as to the basic cause.

Diagnosis

The frequency with which the diagnosis of pulmonary embolism is made varies directly with the alertness of the physician to its possibility of occurrence. This diagnosis is not an easy one,

except in the few cases in which the signs and symptoms are typical. If the patient presents with acute pleuritic pain, dyspnea, cough, and hemoptysis, the diagnosis can be made if it is brought to mind. Often, however, the patient does not present this clear picture and symptoms can vary from none at all to sudden death.

Most patients with pulmonary emboli initially have symptoms referable to the chest; in our experience they have been referred to as either a pain, a catch, a tight feeling, a fullness, an inability to take a deep breath, or a shortness of breath. A few hours later the patient may or may not produce blood-streaked sputum. These symptoms may be confused easily with myocardial infarction, angina, gallbladder disease, indigestion, or pneumonia.

In the examination of the patient we frequently find an elevated pulse rate and localized rales; pleural friction rubs are rarely found as an early sign and are transient when present. The absence of leg signs does not rule out pulmonary embolism; one half of the patients with pulmonary emboli have no signs or symptoms of deep venous thrombosis in the lower extremities. The absence of such signs leads us to believe that over 50 per cent of venous thrombosis originates in the pelvic veins.

Signs which may be helpful in the diagnosis of deep venous thrombosis include: (1) edema, varying from mild swelling at the ankle to massive swelling of the entire extremity; (2) distended pretibial and pedal veins which, in some cases, remain distended with elevation of the foot above the level of the heart; (3) the presence of Homans' sign; (4) localized tenderness over the femoral vein in the groin, which is somewhat more specific than Homans' sign, since finger point pressure on other points of the thigh do not yield the same localized tenderness. If these signs are present along with any of the signs or symptoms of pulmonary embolism, then the diagnosis of embolism is assured.

Conventional laboratory blood studies have been of no use in establishing the diagnosis.

Roentgenograms are an aid in early diagnosis of pulmonary embolism, but are seldom, if ever, conclusive. Reports are usually "compatible with" or "suggestive of" pulmonary embolism. This uncertainty may be due partially to the quality of the films, as they are obtained frequently with portable equipment at the patient's bedside. Hampton and Castleman,[4] in their correlation of x-ray and autopsy findings, came to the conclusion that there were no x-ray findings which might be stated to be typical of, or diagnostic of, pulmonary embolism or infarction.

Electrocardiograms are useful in ruling out myocardial infarction as a cause of chest pain, but are of little immediate positive help in the diagnosis of pulmonary embolism. The electrocardiographic pattern of acute cor pulmonale was evident in about 20 per cent of the 273 patients with this condition reported by Carlotti, Hardy, Linton and White.[5]

Treatment

Treatment of pulmonary embolism and deep venous thrombosis of the legs is similar and inseparable. Prophylactic care of the legs is essential whether the emboli arose from the pelvis or the legs.

The object of treatment is twofold: (1) to avoid fatal pulmonary embolism, and (2) to minimize postphlebitic sequelae. After a base line clotting time is obtained and a one stage prothrombin test is made, treatment is begun with heparin and coumarin drug therapy simultaneously. After using an array of coumarin drugs, we have returned to the use of bishydroxycoumarin (Dicumarol).

The heparin is administered as follows:[6] 50 to 75 mg. is given intravenously and a similar amount is given subcutaneously at the same time. The subcutaneous heparin then is given every four hours. The clotting time is checked once a day thereafter, at a time three and one-half hours after a given dose of heparin. This check insures that the clotting time does not rise progressively to dangerous levels, as may occur after three or four days of heparin therapy. We preferred to have the clotting time (in the third tube of the Lee-White method) drop below 25 minutes at the three and one-half hour check time. If the clotting time at this point is above 25 minutes, the heparin dose should be reduced proportionately. If the clotting time has returned to normal levels, the dosage should be increased.

Dicumarol is given once a day, depending on the prothrombin time as determined that day. It is best to draw blood samples for the prothrombin time along with the clotting time so as to minimize interference of the prothrombin test by the heparin. Dicumarol is administered daily according to the following schedule:

Prothrombin time	Dicumarol
75-100%	300 mg.
50- 75%	200 mg.
30- 50%	100 mg.
15- 30%	50 mg.
0- 15%	omit

After regulation is attained, the prothrombin time can then be checked twice weekly.

When the prothrombin time drops below 30 per cent of normal, administration of heparin is discontinued and coumarin therapy is continued for an average of 21 days. If the patient has signs or symptoms of severe deep venous thrombosis, therapy is extended for four or more weeks, depending upon the rapidly of his progress.

Absolute bed rest in a modified Trendelenburg position, if it is tolerated, is maintained during the first four days. The patient is then gradually ambulated with elastic bandages extending to the knees. Sitting or standing still is discouraged; elevation of the feet and walking are encouraged. Antibiotics are used routinely to prevent secondary infection in the lungs.

Certain contraindications to this mode of therapy are recognized and exist principally when progressive thrombosis or major hemorrhage occurs during anticoagulant therapy. Anticoagulant therapy usually has been unsatisfactory following prostatic surgery because of bleeding from the prostatic bed. Our indications for ligation of the inferior vena cava include suppurative pelvic thrombophlebitis and the need for protection from pulmonary embolism in the face of progressive thrombosis or major hemorrhage with anticoagulant therapy. In many instances the indications for one mode of therapy and the contraindication for another are relative, and in such instances sound surgical judgment should prevail.

Femoral vein ligations have no place in the therapeutic armamentarium for venous thromboembolism.[7] Unlike vena caval ligation, this procedure does not offer a safeguard from subsequent pulmonary embolism as this site is distal to the pelvic veins, the origin of at least 50 per cent of pulmonary emboli. As described, when anticoagulants are ineffective or contraindicated, the site for venous ligation is the vena cava just below the renal vessels.

Means of dissolving intravascular thrombi and emboli have long been sought. Progress has been reported recently with this type of therapy.[8] Human fibrinolysin has proved to be efficacious for the dissolution of recently formed intravascular clots. Success has been achieved in many cases of acute venous thrombosis and pulmonary emboli of less than five days' duration. Beyond this period, there has been too much organization of the clot and lytic action decreases rapidly. Fibrinolysin has a specific action on fibrin, leaving other plasma proteins virtually unaffected. No effect has been noted on the clotting mechanism.

While it may be beneficial in early cases to use fibrinolysin, it should be used with, and not instead of, anticoagulant therapy. The two types of treatment are entirely compatible.

Prognosis

Allen, Barker and Hines[9] stated that if a patient has pulmonary embolism after operation and survives, there is a 43.8 per cent chance of another thrombotic episode, a 30.5 per cent chance of another embolism and an 18.3 per cent chance of a fatal embolism in the same postoperative convalescence.

Recurrences of pulmonary emboli have occurred among patients with adequate anticoagulation as measured by laboratory studies, in approximately 12 per cent of the cases in our experience. These recurrences have been equally divided between patients on heparin and on coumarin therapy. None have been fatal. No pulmonary emboli have recurred after ligation of the inferior vena cava.

The ideal mode of therapy is yet to be discovered. A keen awareness of the possibility of pulmonary embolism, its early recognition, and aggressive anticoagulant therapy offer the patient an exceptionally good chance for recovery.

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Familial Dysautonomia

Recently Discovered Case

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In 1949 Riley, Day, Greeley and Langford[1] presented the case histories of five children manifesting the bizarre symptomatology of a hitherto undescribed psychoneurologic disease. Their article was, in fact, the first presentation of the now recognized disease entity familial dysautonomia or Riley-Day syndrome. Fortified with a total of 33 cases, Riley again reported on the disease in 1952[2] and set forth nine major and minor diagnostic criteria. To date less than 100 cases have appeared in the American literature. This report presents a previously undescribed case of familial dysautonomia seen at the Dade County Child Guidance Clinic.

Report of Case

History.—A six year old Jewish girl was brought to the Dade County Child Guidance Clinic for evaluation of a behavior problem. The parents described her as not getting along with her playmates and siblings, continually disobedient and unable to adjust to minor changes in routine. She was prone to tantrums and unpredictable mood swings, and required constant supervision from her mother.

The patient was born in July 1954 and was the eldest of three girls. Her sisters, aged 28 months and six months, had shown no similar emotional instability. The mother had three spontaneous abortions prior to the patient's conception. This pregnancy was uneventful except for the fact that the mother's physician recommended she remain in bed during the early months of gestation. She received daily hormone injections throughout the pregnancy. Labor was short and was followed by an uncomplicated delivery at a New York City hospital. The mother did not recall the patient's exact birth weight, but stated the obstetrician commented on the child's normality following delivery. After her confinement the mother experienced some type of emotional decompensation lasting several weeks which she termed "the baby blues." The patient was bottle-fed and presented a feeding problem from early infancy. She did not walk until 18 months of age and did not talk in intelligible, simple sentences until 36 months of age. During the first year of life the parents observed the patient to be unusually demanding, irritable, restless and emotionally unpredictable. The mother frankly admitted she did not enjoy caring for this child.

Toilet training was difficult and not mastered until the age of four years. Urinary frequency and enuresis were troublesome problems. She drooled continually until the age of three and one-half years. While living in the northern part of the United States she had had perpetual upper respiratory infections, but there was no history of frank pneumonia. There was also no history of seizures or high fever. The medical history was otherwise benign.

Following the birth of the second child the parents noted an increase in the patient's tantrums, general misconduct, irritability and restlessness. When she was four and one-half years old, she was taken to a private psychologist for treatment, but therapy was discontinued because of financial pressures. Upon the recommendation of the Dade County Board of Public Instruction she was brought to our clinic for evaluation.

Psychological Examination.—The patient was given a battery of psychological tests which included the WISC, Porteus maze, color form, house-tree-person, TAT and Bender-gestalt. The projective drawings suggested strong emotional conflicts centered around the parents, particularly the mother. Color form sorting tests demonstrated poorly controlled compulsivity characteristic of organic brain disease. The verbal I.Q. was 74; performance I.Q. 83; full scale WISC I.Q. 76. The patient's intratest performance on the intelligence test was erratic; she scored above average in some areas and very poorly in others. Such a score pattern has been shown to represent an intelligence higher than the test results would indicate. The child was considered of at least normal intelligence.

Psychiatric Examination.—The patient was a fairly attractive dark-haired girl of good physical proportion. Her gait and body movements were clumsy and ungraceful. Speech was infantile and difficult to understand because of poor enunciation. Throughout the interview she was very restless and hyperactive; she was constantly fidgeting in her chair, jumping to her feet without provocation to walk about the office. Meaningful conversation was difficult because of loose associations, short attention span and an aimlessly wandering train of thought that often changed course in the midst of a sentence. In the play room her short attention span was again noted. Play was disorganized, chaotic, and destructive.

Neurologic Examination.—The weight was 26 Kg., the height 122 cm., the pulse 110 and regular, respirations 26, and blood pressure in a sitting position 110/60 mm. Hg and stable. The patient was awkward and devoid of poise. Rapid movements were poorly performed; she could neither skip nor hop. An articular speech impediment was evident. There was a general hypotonicity of skeletal muscle and hyperextensibility at the major joints. Deep tendon reflexes were not remarkable, and no pathologic reflexes were noted. An unusual tolerance to the pain of a pin stick was demonstrated. It was at this point that the mother mentioned that the patient had never had tears while crying until she was five years old. An electroencephalogram was performed without sedation and interpreted as being within the range of normal variability in accordance with her age group.

Evaluation Summary.—It was concluded that this girl was suffering from an organic brain disorder manifested by motor, intellectual, emotional and vegetative impairment. The symptom complex was found to be compatible with the diagnosis of familial dysautonomia.

Discussion

Riley's tabulation of the diagnostic criteria was based on 33 cases of familial dysautonomia, as shown in the accompanying table.[2] Since 1952 the number of verified and studied cases has

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Occurrence of Features in Thirty-Three Cases[2]

Feature	Number Cases With Information Available	Cases With Feature	
		Number	Per Cent
Group A			
1. Jewish extraction	33	33	100
2. Defective lacrimation	33	33	100
3. Skin blotching	31	30	97
4. Excessive perspiration	31	31	100
5. Drooling	27	27	100
6. Emotional instability	30	30	100
7. Motor incoordination	27	27	100
8. Hyporeflexia	31	30	97
9. Relative indifference to pain	22	22	100
Group B			
1. Hypertension	27	23	85
2. Cyclic vomiting	30	19	63
3. Frequent pulmonary infection	31	23	74
4. Frequent unexplained fever	24	16	67
5. Breath-holding spells in infancy	22	16	73
6. Urinary frequency	24	18	75
7. Mental retardation	31	17	55
8. Convulsions	32	16	50
9. Corneal ulceration	31	11	35

nearly tripled, and the original list of criteria remains valid with only minor changes. The disease still characteristically affects children of Jewish extraction; however, two cases have been observed in non-Jewish children.[3,4] The "hypertension" seen in 85 per cent of the cases has been found actually to be a vasomotor instability with orthostatic hypotension and overcompensatory hypertensive episodes of short duration. The factor of mental retardation is no longer considered valid.[5] With recent advances in psychologic testing and better understanding of the adverse effect emotional turmoil has on demonstrable intelligence, children with this disease are considered to be no more likely to be mentally retarded than the rest of the population.

In approximately one fifth of all reported cases the patient has died, usually under the age of three years and usually as a result of overwhelming pneumonia. Postmortem examination of the brain in 10 cases has shown nothing consistent or striking. In one case[6] a cyst was found involving the dorsomedial nucleus and the lateral nucleus of the thalamus with rarifaction of the reticular formation in the pontine, medullary and upper cervical region of the brain stem. A carefully conducted gross and microscopic brain examination by Cohen and Solomon[7] revealed a degenerative process confined to the reticular formation of the lower pons and medulla involving several cranial nerve nuclei in the floor of the fourth ventricle.

The familial nature of the disease is well established. Various studies have reported that between 25 per cent and 35 per cent of siblings have some degree of affliction.[8] Riley, Freedman and Langford[3] set the figure at 33 per cent and considered the disease to be genetic in nature transmitted as a Mendelian recessive. The Riley-Day syndrome is tentatively considered to be a familial degeneration of the central nervous system involving predominantly the reticular formation and the hypothalamic tracts in that area.

Treatment of the whole syndrome has, so far, been uniformly unsuccessful. Treatment of the more serious symptoms and complications such as severe vomiting, dehydration, corneal ulcers and pneumonia has been gratifying.

The problems of drooling, vomiting, tearlessness and respiratory infection usually show definite improvement as the child progresses beyond the age of five years; psychological factors become increasingly more important. At this age children become aware of the fickle, fluctuating and often cruel social world of their peers. Their awkwardness and indescribable strangeness come into sharp focus and add to the already crippling emotional burden. If these children live beyond the age of four years, supportive psychotherapy for the patient and parents will allow for a fuller and happier life for all concerned. Riley and his associates[3] concluded that there may be many children and young adults suffering from familial dysautonomia whose condition has been

misdiagnosed as schizophrenia or mental retardation, and they have been placed in institutions or kept at home as "hopeless cases."

Summary

A case of familial dysautonomia is presented which demonstrates many of the salient features of this bizarre disease. Particular emphasis is placed on the need for early diagnosis, the increase in morbidity of the psychological aspects in the face of improvement in some of the physical components and, most important, the need for supportive psychotherapy for both patient and parents. Barring complications the patient with the Riley-Day syndrome is not a candidate for an institution or a reclusive life at home.

Appreciation is expressed to Dr. Leonard I. Lesser, Director of the Dade County Child Guidance Clinic, and Dr. Peritz Scheinberg, Head of the Department of Neurology, University of Miami School of Medicine, for their help and advice.

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The Atypical Acid-Fast Bacilli In Florida

Observations on Their Epidemiology

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Bacteriologists have been aware of atypical (anonymous) acid-fast organisms for as long as they have been culturing sputa for acid-fast bacteria. There are many reports in the bacteriologic literature describing highly pigmented acid-fast bacilli.[1-6] Even the concern of clinicians is not new. Pinner[7] in 1935 emphasized the need of a critical evaluation of the significance of these atypical forms associated with human disease. Interest in Florida in this special group of organisms began in 1955 when a particularly competent and well trained mycobacteriologist joined the staff of the Tuberculosis Hospital Laboratories. He had seen these organisms on cultures for many years. They were not isolated frequently and when found were considered saprophytes and discarded. In Florida it was apparent that he was seeing these so-called saprophytic forms more frequently than he had previously. He felt obligated to report them to the doctors. It became apparent to the clinicians of the Florida Tuberculosis Hospitals that these organisms were being recovered consistently from the sputa of certain patients. It was noted further that the patients discharging these organisms did not respond typically to the usual antituberculosis drugs; in general, these patients did poorly.

As a result of these preliminary observations of both bacteriologists and clinicians, the Florida State Board of Health and the Florida Tuberculosis Hospitals undertook a cooperative investigation into the epidemiology and the clinical significance of these organisms.

The atypical acid-fast organisms, as a whole, are easily differentiated bacteriologically from Mycobacterium tuberculosis. They are subdivided into four groups designated with Roman numerals I, II, III and IV. This classification is based upon the work of Dr. Ernest Runyon[8] of the Veterans Administration and depends upon the temperature requirements for growth of these organisms, their ability to produce various pigments when exposed to light, their rate of growth, their uniform avirulence for the guinea pig and their pathogenicity for certain other laboratory animals.

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Table 1.—All Identified Atypical Acid-Fast Bacilli Cases By Group Florida 1956-1959

Atypical Group	Total Cases Number	Per Cent
I	29	4.9
II	74	12.6
III	428	73.2
IV	54	9.3
Total	585	100.0

Group Incidence

Table 1 depicts according to the group of organism all of the atypical cases which have been identified in Florida since late 1955. These data represent the results of routine examinations of all specimens submitted to public health, tuberculosis hospital and other laboratories for acid-fast cultures. Through this four year period, 585 cases have been uncovered. It is noted that approximately three fourths of them yielded the Group III organisms. Reports from other states indicate that the Group III cases are found predominantly in the Southeastern United States. Other regions have identified Group I infections more commonly. Only 4.9 per cent of the Florida cases are due to this group. The more highly pigmented varieties of Group II accounted for 12.6 per cent of the cases, while Group IV, the rapid growers, were isolated from 9.3 per cent.

The Group I organisms (photochromogens) have not been found in the absence of associated pathologic processes. They appear to be distinct pathogens. On the other hand, the atypical acid-fast bacilli of Group III (nonphotochromogens) may be found in persons who have no apparent disease. In over half the Florida cases, however, there is definite pathology associated with this infection. The Groups II and IV (scotochromogens and rapid growers, respectively) are only rarely isolated from disease states in which they appear to play a causative role.

Analysis of Cases

The pulmonary disease with which these organisms are associated is clinically indistinguishable from tuberculosis; the differentiation depends solely upon bacteriological studies. An exact etiological diagnosis, however, is needed for the proper medical management of patients infected with atypical acid-fast bacilli. These patients should be isolated from those excreting M. tuberculosis. Their therapy should be guided by in vitro drug susceptibility tests against their specific atypical organism. If satisfactory resolution of their pneumonic process is not apparent in a short time on conservative therapy, they should have early consideration for the surgical removal of the diseased portion of their lungs.[9,10]

To date, adequate clinical records have been obtained on 386 (90 per cent) of the 428 persons in Florida from whom Group III atypical mycobacteria have been isolated. In 146 (38 per cent) of the 386 cases there is reasonably secure evidence of a primary cause-effect relationship between the atypical organism and demonstrable pathology. Four of these had clinical evidence of acid-fast disease of the kidney and 142 had x-ray evidence of pulmonary pathology. All had yielded only Group III atypical mycobacteria upon repeated examinations, and no other cause for the disease state has been identified. In 16 (4 per cent) of the 386 cases yielding these organisms there was no apparent abnormality, either radiologically or clinically. In the remaining 224 (58 per cent) either there was bacteriological and/or clinical confirmation of other primary or associated causes to explain the manifest disease, such as M. tuberculosis or other specific disease, or sufficient evidence was lacking to incriminate securely the atypical organism, for example, only single isolations from multiple examinations.

Thus, evidence justifying an assumption of a primary etiological relationship between the Group III atypical mycobacteria isolated and pulmonary disease has been obtained in less than one half of the Florida cases. The frequency with which these organisms were found in persons with other demonstrable causes of pulmonary disease was impressive. In many cases other pulmonary disease or altered pulmonary function appeared to precede infection with the atypical mycobacteria; in these cases they appeared to serve as secondary rather than primary etiological agents. Though cases coming to the attention of the investigators were almost exclusively those being examined for mycobacteria because of chronic pulmonary disease in the individual or in the family, several cases presented evidence suggesting that these organisms may have etiological roles in other diseases: chronic infections of the kidney, chronic abscesses of joints and, in some cases, an acute self-limited pneumonitis.

A notable observation concerning infection in any system and by any of these groups of atypical mycobacteria is their general drug resistance, even upon original isolation from patients with-

Table 2.—Results of Skin Tests with PPD-S and PPD-B in First and Second Grades of Selected Public Schools Florida 1959-1960

Race	Number Tested	Positive Reactors*			
		PPD-S**		PPD-B***	
		Number	Per Cent	Number	Per Cent
White	1,275	13	1.0	45	3.5
Negro	402	7	1.7	66	16.4
Totals	1,677	20	1.1	111	6.6

*9 mm. or more induration.
**PPD-S—Standard Tuberculin (Typical), 0.0001 mg.
***PPD-B—Battey Strain Tuberculin (Atypical), 0.0001 mg.

out previous exposure to chemotherapeutic agents. Drug susceptibility tests are indicated to guide the choice of chemotherapeutics.

Research Project

The need for a careful study of these organisms and the associated diseases is clearly apparent. Their source(s) and mode(s) of transmission, as well as their communicability and infectiousness, are unknown. With these questions to be answered, a research grant was approved by the National Institutes of Health and a study became fully established in early 1959. Presently, this special study revolves about three intimately related primary objectives: the source, the method(s) of transmission and the man to man communicability of these organisms.

To date, tuberculin tests, chest x-rays and sputum cultures have been made on household associates of 80 patients known to be infected with Group III atypical mycobacteria. Fifty-two of these contacts were skin-tested with the atypical tuberculin (PPD-B*) prepared from the Battey strain (Group III) atypical organism: 10 (19.2 per cent) were positive with induration above 8 mm. Of 182 contacts tested with typical tuberculin (commercial PPD or PPD-S*), in seven (3.8 per cent) the reaction was positive. If PPD-B positivity represents past exposure to the Group III atypical mycobacteria, these preliminary results of contact examinations suggest a very low rate of cross infection among household associates.

Sputum has been obtained for bacteriologic examination from household contacts of only three patients with Group III atypical bacilli. Thirteen specimens, in all, were examined: two (15.4 per cent) gave positive results. It is notable that both of these, each identified as Group III atypical mycobacteria, came from the same household. This particular family group is of special interest. The index case was that of an elderly Negro man, who lived on a farm in a predominantly rural county. Multiple sputum examinations and gastric lavage specimens all gave negative results after the original single isolation of a Group III atypical organism. He had no active pulmonary disease and denied any history of pulmonary symptoms. Sputum specimens obtained by aerosol bronchial lavage from five of his 11 household contacts yielded atypical acid-fast organisms from two adults, his wife and a daughter. Neither of these had any abnormality by chest x-ray, and both denied pulmonary symptoms. Interestingly, of the three bacteriologically positive persons in the household, only the wife demonstrated sensitivity to the atypical tuberculin (PPD-B); her response was completely negative to typical tuberculin (PPD-S). No other member of the household (including the index person) gave a positive reaction to either tuberculin.

To gain further insight into the natural history of these infections, special tuberculin surveys have been undertaken in selected parts of Florida. Table 2 reflects the results of Mantoux tests with typical (PPD-S) and atypical (PPD-B) tuberculins* among first and second grade public school children in three selected counties. The 1,677 children tested constitute more than 90 per cent of the total first and second grade enrollment in these counties. Note that 1.1 per cent of this six to eight year age group gave a positive reaction to PPD-S with induration above 8 mm. The reaction rate to PPD-B was considerably higher, 6.6 per cent. There was no significant racial difference among PPD-S reactors, but 16.4 per cent of the Negro children and 3.5 per cent of the white children reacted positively to PPD-B.

The total follow-up of these surveys is not complete, but 69 children who reacted positively to one or both antigens have had chest x-rays. Sixty-seven (97.1 per cent) were without any roentgenographic sign of pulmonary abnormality.

*Special tuberculins were furnished by Dr. Lydia B. Edwards of the U. S. Public Health Service.

Table 3.—Results Of Skin Tests Among Household Contacts Of School Children With Positive Tuberculin Reactions Florida 1959-1960

Index Person Type	Race	Number	Number Tested	Positive Reactors* Among Contacts PPD-B** Number	PPD-B** Per Cent	PPD-S*** Number	PPD-S*** Per Cent
School child with positive PPD-B	White	27	90	22	24.4	1	1.1
	Negro	28	101	35	35.6	8	7.9
	Total	55	191	57	29.8	9	4.7
School child with positive PPD-S	White	7	16	1	6.2	6	37.5
	Negro	7	30	5	16.6	2	6.6
	Total	14	46	6	13.0	8	17.3
Totals		69	237	63	26.5	17	7.1

*9 mm. or more induration.
**Battey Strain Tuberculin, 0.0001 mg.
***Standard Tuberculin, 0.0001 mg.

Two (2.9 per cent) demonstrated diagnostic evidence of active primary tuberculosis. These were nonrelated, nonassociated Negro females who attended different schools. In one of them the reaction was positive to both antigens with 26 mm. induration to PPD-S and 16 mm. to PPD-B. Of more interest was the other child who reacted only to PPD-B with 17 mm. induration. Aerosol bronchial lavage specimens from each of these gave negative response on culture. For bacteriologic examination, specimens were obtained by aerosol bronchial lavage from most of these children reacting positively to either or both antigens. To date, cultural studies have been completed on 75 of them: one (1.3 per cent) yielded an acid-fast organism identified as a Group III atypical acid-fast bacillus. A chest x-ray on this child was normal. There was no history of pulmonary symptoms.

The household associates of 55 school children whose reaction was positive to PPD-B alone and 14 school children who reacted positively to PPD-S alone were examined with tuberculin tests, chest x-rays and sputum cultures. The results of these studies are summarized in table 3. One hundred and ninety-one household contacts of the 55 school children whose reaction was positive to PPD-B were tested with both PPD-B and PPD-S. In 57 (29.8 per cent) the reaction was positive to PPD-B with induration above 8 mm.; in only nine (4.7 per cent) was it positive to PPD-S. Forty-six household associates of the 14 school children reacting positively to PPD-S were tested with these two tuberculins; in eight (17.3 per cent) there was a positive response to PPD-S and in six (13.0 per cent) to PPD-B. It is recognized that these studies need to be extended; nevertheless, the preliminary figures indicate a definite family clustering of persons exposed to Group III atypical organisms or to antigenitically similar agents.

Ninety-two household associates of the 69 school children reacting positively to either of these two tuberculins received chest x-rays. It is outstanding that 91 of these were without any roentgenographic abnormality. Only one (1.1 per cent) demonstrated signs suggesting tuberculosis. This person and one of the two children with a diagnosis of primary tuberculosis were members of the same household and contacts of a person known to have tuberculosis.

Sputum specimens for bacteriologic culture were obtained from 119 household associates of the 69 school children reacting positively to tuberculin. These included 43 specimens obtained by aerosol bronchial lavage on children between the ages of five and 13 years. Of the 119 specimens, three (2.5 per cent) yielded acid-fast organisms —Group III atypical acid-fast bacilli. Two of these were isolated from children. The third was isolated from an adult white male. One of the two children with a bacteriologically positive result was a sibling of the only student (noted previously) yielding a positive culture. These three children with a bacteriologically positive response lived close together in a small Negro community. The single adult yielding a positive culture reacted to PPD-B with 10 mm. induration; he was the father of a school child reacting positively to PPD-B. In none of these persons with bacteriologically positive reactions was x-ray or clinical evidence of any pulmonary disorder demonstrated.

Comment

It appears that the Group III atypical organisms are widely distributed. If it can be assumed

that PPD-B sensitivity is indicative of past exposure to these organisms, results of tuberculin tests indicate that these are not uncommon infections and that a fairly large percentage of the population comes in contact with them early in life. Our limited epidemiological data suggest a familial clustering of these infections; but there is no evidence that they are commonly transmitted from human to human. Regarding their source, there is reason to suspect an extra-human reservoir, perhaps the soil. The atypical mycobacteria have been found associated with acute processes frequently enough to raise the question of whether or not they play a causative role in pulmonary diseases of short duration. The history in many cases supports the view that the Group III atypical acid-fast bacilli are "opportunists" and become capable of producing serious respiratory disease only after the normal pulmonary resistance has been lowered from other causes. Place of birth, place of residence, occupation, race, age and associated diseases all appear related to frequency of infection by Group III atypical mycobacteria, but these relationships are ill-defined and poorly understood.

Summary

These infections are presently under careful study by many workers in the United States. The consensus is that the Group I atypical organisms are true pathogens capable of producing progressive pulmonary disease clinically indistinguishable from that produced by M. tuberculosis. The Group III organisms, on the other hand, appear less capable of causing progressive disease, but should be considered potential pathogens whose clinical significance in any particular case must be evaluated through multiple sputum examinations and accessory clinical studies. The Groups II and IV are generally saprophytic and usually of no clinical importance in the respiratory system; however, they have been incriminated in chronic abscesses and in an occasional case of pulmonary disease. Here again, their significance in a particular patient must be evaluated through multiple sputum examinations and the absence of other recognized pathogens. The acid-fast bacteria (the mycobacteria) should be considered in the same light that other micro-organism groups are viewed which contain true pathogens on one end of the scale and definite saprophytes on the other end. One's basic knowledge of the pathogenesis of disease and best medical judgment serve as a guide in assigning significance to the presence of a particular bacterium.

Most authorities agree that these diseases should be handled as serious communicable infections in a manner not differing from that recommended for tuberculosis until such times as a better understanding of their epidemiology would dictate differently.

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P. O. Box 210.

President's Page

What Shall the Florida Medical Association Do About the Osteopaths?

This is a question which has been plaguing us for several years. Part of the time the Florida Medical Association has been acting like an ostrich and burying its head in the sand so as not to see the situation at all. At other times, if we dared look at the situation, we simply swept it under the rug to be disposed of at a later and more convenient date.

I believe the action of the House of Delegates at the last American Medical Association meeting will force us to take some positive action.

The following is a statement of the American Medical Association policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist; that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in a science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to reappraise its application of policy regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical."

I feel that we can all agree on the first two statements without much discussion.

Number three is certainly open for debate. Are doctors of osteopathy actually going through a transitional stage and giving their patients scientific medical care or, on the other hand, are they still trying to pretend that they are and yet hold on to their cultist teaching? This is something which has got to be determined.

Number four states that the colleges of osteopathy have modeled their curricula after medical schools. This is based on a view that there is an almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and on the fact that many doctors of osteopathy are no longer practicing osteopathy. It has been my understanding that the teachers in osteopathic schools are mainly osteopaths and no doctor of medicine has been allowed to teach in these schools. How then can these men be doctors of medicine when they have had no training or formal teaching in the science of medicine?

Statement number five is the old army game of "passing the buck." How are we to ascertain whether osteopaths are practicing a method of healing founded on a scientific basis? Shall we ask that all osteopaths now practicing in Florida go back to school and get an M.D. degree? Shall we ask all to pass a certain type of medical examination to determine their fitness to practice medicine on a scientific basis? Shall we in our great wisdom, however, come out and say that all osteopaths are qualified to practice scientific medicine with all the equal rights of doctors of medicine?

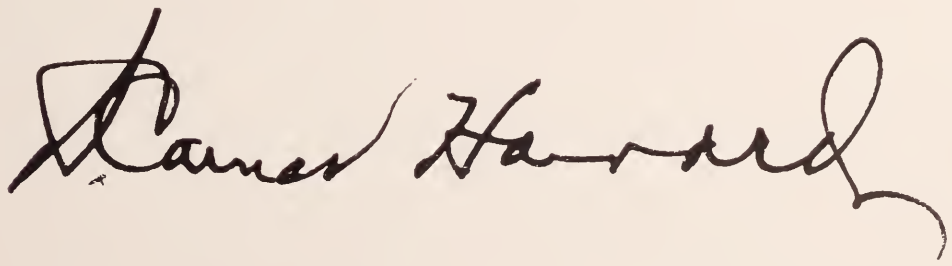
In my opinion until osteopaths have had equal training and education with doctors of medicine they should not be recognized. Those men who are now osteopaths and practicing in Florida should not be recognized unless they take further training and pass examinations along with doctors of medicine.

In the future, I think all of this can be eliminated by converting the osteopathic schools into medical schools with the same curricula as existing medical schools, taught by doctors of medicine. I have no quarrel with osteopaths personally as no doubt there are many fine men who believe in the osteopathic approach to healing as much as I do the medical approach. This does not mean, however, that I have to accept something in which I do not believe.

The American Osteopathic Association has openly opposed any amalgamation or close cooperation with the American Medical Association.

Here in Florida the president of the Florida Osteopathic Association, George W. Frison Sr., in the June issue of the Journal of the Florida Osteopathic Medical Association, made this statement: "At present, in my position as President of my state organization, I can assure you that the osteopathic profession in the State of Florida is not now, has not been in the last 26 years, nor is contemplating any negotiation toward amalgamation with either the divisional society of the American Medical Association or the American Medical Association itself."

In my opinion, there is nothing to be gained by the medical profession or the public in pursuing this matter further. Our position remains the same: That the practice of osteopathy constitutes cultism and there can be no ethical professional relations between doctors of medicine and cultism.



Not by Bread Alone

That man does not live by bread alone is a truism which hardly warrants repeating, certainly not to members of a profession whose basic philosophical thesis is that the good of the patient comes first. It should be equally obvious that man cannot live completely without bread, and that these two ideas are not diametrically opposed or in conflict with each other. Unless he is independently wealthy, the doctor who disregards the economic aspect of the practice of medicine is not likely to be able very long to render service to humanity because his creditors will not share his unconcern for such mundane matters as money.

Physicians should have no guilt complex about what is termed by short-sighted and unfriendly critics as profiting from illness. The "profiting," if any, is from restoring people to economic productivity. The difference in emphasis in these two points of view is a very important one.

In spite of the altruism that surrounds the practice of medicine, society recognizes the doctor as an economic entity. To cite a few instances: The drives for the United Appeal, Cancer Fund, YMCA, University Alumni Fund, AMEF, and so forth ad infinitum, are always liberally supplied with names of doctors who are potential big donors. The soaring rates of professional liability insurance in the past 15 years attest to the fact that doctors are soft touches for big settlements for alleged malpractice. The drive by labor unions and others to set up closed medical panels and thus to "control" the costs of medical care are becoming more insistent. Since 1946, there has been constantly in motion in the Congress, an effort to have the federal government take over the practice of medicine.

Since the government, organized labor, and the public in general have shown intense interest in the economic aspect of the practice of medicine, it is sheer professional suicide for the medical profession to continue to ignore or to take a half-hearted interest in its own welfare. And how does it go about changing this situation? No one can answer in a few sentences, but here are a few suggestions:

1. About fees:

The doctor who thinks he sets his own fees is only kidding himself. All he has to do, to get some insight into how his fees were arrived at, is to watch the newly arrived doctor in town. He asks what others charge for various procedures, and soon he has established for himself "acceptable" fees, that is, fees which are acceptable to his patients and to the other doctors in the community. If he varies very much from the usual, he will hear about it from his patients. Once a doctor has decided upon a fair price for his various services, he should make sure his patients understand. The patient who believes he has been overcharged usually does not understand for what he has been charged; he is no different in his injured feelings from the doctor confronted with an unitemized bill for automobile or television repairs. Most people are willing to pay the price if they know what they are buying and have been convinced of its worth.

2. About fee schedules:

Fee schedules with their implied equality in the ability of doctors, in disease, and in patients are anathema to physicians but they are here to stay, like it or not. The question is: who will create these schedules, laymen or doctors? So long as there are pooled funds to provide payment for medical services by someone other than the one who received the services, there will have to be some means of assuring the equitable distribution of these funds. If the funds were unlimited, there would be no need for fee schedules; however, since the funds are limited, no matter how great the total amount, the best way to assure that each doctor will get his fair share is for the doctors themselves to do the dividing. This is the rationale behind the relative value system for fee scheduling which has been adopted by the Association.

3. About professional and personal liability:

The professional liability insurance problem has been almost insoluble. The consensus of experts is that the only way to stem the constant increase in premium rates is to take group action in fighting all unwarranted claims and in reducing the cost of acquisition and of servicing the insurance. After ten years of effort on the part of the Association, it appears that a group professional liability insurance plan will soon be offered to members. When this becomes available, it will behoove the doctors of Florida to support it.

4. About lost income from illness:

For the past six years, the Association has offered its members the finest group health and accident insurance which could be bought. Because the average age of doctors in the Association is about 40, the loss experience under this policy has been phenomenally good. To date, there have been three increases in benefits, without increase in premium rates, and one reduction in rates. Those doctors who need this kind of insurance (and who does not?) are missing a good bet if they are not participating in the Association plan. Other insurance to cover accidents and office expenses incurred during illness also are available.

5. About retirement income:

The Association has been offering for several years a combination annuity, stocks and bonds and insurance program entitled "Florida Medical Association Investment Trust" whereby members may set aside regularly certain sums of money for retirement and be assured of professionally competent management of their funds under the supervision of the Association.

6. About the economic problems of operating an office:

With this issue of The Journal begins a new feature in which individual problems of general interest on subjects of economic interest may be submitted to a professional management group for consideration. Replies will be published in The Journal. This service could be of inestimable value to the doctors of Florida and it is hoped that it will be freely utilized.

In conclusion, more hackneyed ideas come to mind: in unity, there is strength; two heads are better than one; united we stand, divided we fall. In short, the problems of the doctor in particular are usually those of medicine in general, and their best solution is usually achieved through group action. Your Association is an instrument of service to the medical profession in Florida. Its success in accomplishing its purpose depends on the active participation and interest of all its members in all of its affairs.

Robert E. Zellner, M.D.
Orlando

The American Way of Life

The Philippine ambassador to the United States, General Carlos P. Romulo, appearing before the National Red Cross in Cincinnati, Ohio, stated: "The American way of life is not an ideology; it is a real way of life. The truth is that Americans are a spiritual people and they show this most strikingly by the way they care for the aged, crippled and infirm. The rest of the world must be made aware of the contrast between the materialism of Communism and the spirituality of the American way of life."

We as physicians are responsible for the aged, crippled and infirm, and so can correctly assume that a portion of General Romulo's statement reflects some credit upon our profession.

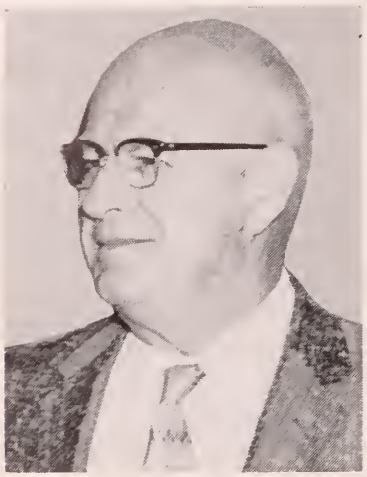
The second portion of this statement concerns the need for educating our world community to know the true nature of the American citizen and to judge us by this knowledge rather than by that impression created from Communist propaganda, American commercial advertisements, and some of our public servants who are more materialistic than is good for our reputation.

This process of education requires individual effort directed toward other individuals with similar interests and, if possible, educational backgrounds. With this in mind should we not: invite our Southern neighbors to the annual meeting of the Florida Medical Association; furnish copies of The Journal of the Florida Medical

Association for the libraries of the universities in the Caribbean, Central and South America offering courses in Medicine; organize a task force of well informed physicians capable of teaching and willing to participate in seminar discussions, in any area requesting this service?

Admittedly these suggestions are only a start, yet by offering these courtesies, and by showing this interest, the picture of an American may become more real and mutual understanding may grow.

T.M.



Dr. Pearson

Those Who Serve

A Tribute to Dr. Homer L. Pearson Jr.

By his election to the Board of Trustees of the American Medical Association at the June meeting in New York, Dr. Homer L. Pearson Jr. of Miami has been signally honored by his colleagues. Those of us who know him and have served with him professionally or in his duties with the Association were not surprised at this honor for he is a man who inspires confidence, invites cooperation, and epitomizes the practice of medicine in his every action—a physician who is kind, considerate, patient, understanding, sympathetic, yet firm and unyielding when necessary.

Dr. Pearson, chairman of the Judicial Council of the Florida Medical Association and formerly chairman of the American Medical Association's Judicial Council, represents the life to which he is dedicated. He has never worn two hats—one as a physician and one as an organization man. On the contrary, he has been the Physician at all times and in every sense of the word. We are proud that he has been chosen to represent all physicians at this crucial time when change in the traditional and proved concepts of rendering medical care is being proposed for reasons of political expediency.

As special tribute is paid to Dr. Pearson, we also recognize with appreciation the many physicians who have given unselfishly of themselves and their time to participate in activities which seek to preserve the rights to which medicine and the public are entitled. Chosen as leaders, these men have great responsibility. They deserve and must have our support.

REUBEN B. CHRISMAN JR., M.D.
CORAL GABLES

Medical Library Facilities for All

What library facilities are available to the isolated physician in the small community? Can he obtain good literature review to help him in studying his patients? Suppose he has an interesting case to report to his colleagues or a small clinical investigation. Where can he get library assistance? Let us approach this problem.

Report of Case

J. O. Blough, M.D., Mosquito Beach, recently had two patients with "Skronk's disease." In both cases the "serum rhubarbase" was elevated. Blough found no reference to this phenomenon in available books and journals. He would like to check this further. Perhaps he might prepare a report for the county medical society meeting or for publication. There seem, however, to be no medical library facilities in Mosquito Beach. Dr. Blough is concerned (fig. 1) since his books and journals seem inadequate. Let us list the resources available to him:

1.—NEARBY HOSPITAL MEDICAL LIBRARIES: No matter how small, these will usually have the Index Medicus (formerly the Current List of

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From the Baptist Memorial Hospital, Jacksonville.
Illustrations by Miss Frances Houston, MT(ASCP), Section Head, Chemistry.
Material compiled by Mrs. June King, Medical Librarian.
Read in a panel discussion on "Getting Research Started," College of American Pathologists meeting, Chicago, Sept. 27, 1960.

Medical Literature). Dr. Blough should check "Skronk's disease," "serum rhubarbase," names of organs involved, and key authors. Now he can make a card index of promising articles, preferably in available medical journals. Those in the hospital library can be checked, and their reference lists utilized. Dr. Blough can request from their authors reprints of the most pertinent articles.

2.—Florida State Board of Health (P.O. Box 210, Jacksonville 1): Offers the following services to physicians of the state:

A. Loans books and journals.
B. Obtains photostats from the National Library of Medicine free of charge or from the Library of Congress at 20 cents per page.
C. Prepares (without charge) bibliographies from the medical indexes.
D. Checks bibliographies for correctness of citation.
E. Offers general bibliographic assistance.

3.—University of Florida (Gainesville) Health Center Library:

A. Furnishes photoduplicated copies of requested articles (20 cents per page) published since 1945.
B. For material prior to 1945, loans bound volume of journal, with borrower paying all postage.
C. Loans books on an interlibrary loan basis.
D. Will send one or two pertinent articles on any requested subject.

4.—Florida Medical Association: Loans available journals.

5.—Texas Medical Association (1801 North Lamar Boulevard, Austin): Now owns the reprint collection of the American College of Surgeons. Provides package library service to all Fellows of the College without charge save for return postage.

6.—American Medical Association: Loans packages of reprints of pertinent articles.

7.—Special Societies: For example, the American Cancer Society (521 W. 57th St., New York 19, N. Y.) publishes reference lists in neoplasia, which will be mailed without charge and furnishes its own published material.

8.—National Medical Library (Washington 25, D. C.): The world's largest, most complete medical library:



Fig. 1.—J. O. Blough, M.D., Mosquito Beach, is disconsolate, since he has only one book and one journal in which to look up the "serum rhubarbase" in "Skronk's disease." In the great wide blank U.S.A. there seems to be no help.



Fig. 2.—Ghost writer.

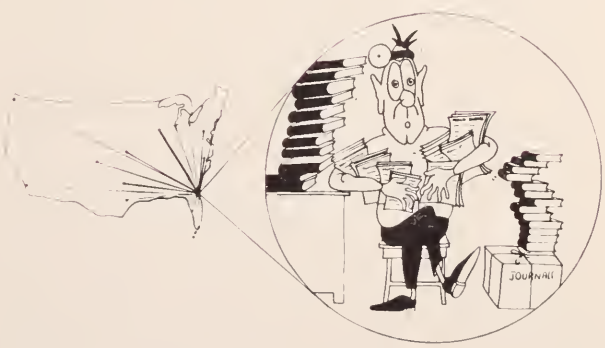


Fig. 3.—Medical libraries in all parts of the U. S. are rushing material to J. O. Blough, M.D., and he is deluged with books, journals, reprints and photostats.

A. Loans only through local (hospital) libraries. Full bibliographic information must be furnished.
B. Supplies photocopies (without charge) of publications not available locally.

9.—PROFESSIONAL REFERENCE SERVICES: For example, the John Crerar Library (86 East Randolph Street, Chicago 1) searches and prepares bibliographies and abstracts for average fees of $7.50 per hour, technical staff, and $3.00 per hour, clerical staff. Translations are also made.

10.—GHOST WRITERS (fig. 2): We hope Dr. Blough will not patronize these.

Comment

After seeking such help, Dr. Blough may find himself swamped (fig. 3). What shall he do with all this material? Drastic though it may sound, we strongly urge that he read it, even at the cost of time for TV and golf. Dr. Blough needs to be familiar with the important articles in the field. A literature review should usually be a means to an end, and not an end in itself. By using the facilities listed, Dr. Blough can, with some time and effort, have as good library service as that available in the biggest medical center.

ALVAN G. FORAKER, M.D.
800 MIAMI ROAD
JACKSONVILLE

OTHERS ARE SAYING

Management of Mass Casualties

by DR. BERNARD YESNER

Civil Defense is as essential for the survival of our country as Military Defense. The impact on the population of the use of nuclear, chemical or bacteriological weapons, in either a limited or general war; or a natural disaster as a severe hurricane or tornado is far reaching. The threat of these types of warfare, with its capability of mass destruction of huge elements of this country, has imposed on the Medical and allied health professions a tremendous responsibility in this nation's effort to survive a catastrophe.

The prime objective of civil defense is the preparation of the individual and the family for a war time attack, or disaster and for their protection and preservation of life before and after a catastrophe. The objective also includes the immunization for control of disease and instruction of population in all facets of self help.

These factors put a most severe burden on the medical and allied professions, who must assume an extremely larger role in the defense of our country and in saving the lives of our fellowman. Thus, First Aid is the crux of the medical care.

Management of Mass Casualties

In Medical Care, we must also realize that the patient has to be treated as a whole, that there is no place for specialization in Emergency Mass Care and that full care is mandatory with every physician doing his part in the general therapeutic regimen.

We have to plan and have an understanding of Mass Care in that in a disaster (whether civil or military) the individual and the nation must continue to exist. A nation's most priceless and fragile commodity is the human being who is, unfortunately, sensitive to radiation, blast, thermal, chemical, bacteriological, psychological and other injuries.

Emergency Medical Care (self-aid or buddy care) of the first 48-96 hours is the most important part of Mass Care, in that it will have to be life saving and life sustaining because untrained personnel will care for the injured. The purpose of First Aid is to:

1. Restore life
2. Restore casualty to a useful state
3. Prevent physical deterioration until more definite treatment can be given.

First Aid or Survival Care—

General Principles of First Aid

1. Never get excited—Act quickly and efficiently.
2. Keep the patient lying down with the head level until he is examined for injuries.
3. Remove enough clothing to get a clear view of the injury.
4. Examine the patient for shock, hemorrhage and cessation of breathing.

First Aid or Self Care has the following purposes:

1. Control Hemorrhage—with pressure bandage or tourniquet. Remember, that in mass care, the patient may be unattended for long periods of time and a tourniquet may be left on the extremity for the same length of time. It would be best, tho' to use mechanical pressure for the control of hemorrhage rather than a tourniquet.
2. Keep the patient breathing using the now-

accepted method of mouth to mouth breathing. The procedure is as follows: Clear the throat of obstructions. Tilt the head back and extend the neck. Lift the jaw forward and keep the mouth open. Pinch the nostrils closed. Form a tight seal with your lips. Blow until you see the chest lift. Remove your mouth and inhale-then repeat the process.

3. Splint fractures 'where they lie.'
4. Dressings or bandages on the wounds. To close sucking wounds of the chest and to cover the wounds so that infection will not be introduced.
5. Handle the patient as an individual. Help to allay his fear and anxiety.

The most important key to Mass Care is Sorting or triage. It is the classifying of the injured and types of injuries into categories so that the patient can be properly routed for further care. It is the philosophy of spending less time with patients with little hope of survival, and more time with those who are salvagable.

The Four Categories in Sorting Are:

1. Minimal Injuries—40%—Most can return to some duty. Includes simple fractures, lacerations, contusions, mild burns of the hands and face and moderate neuro-psychiatric cases.

2. Immediate Injuries—20%—*First Priority*. Includes easily controlled hemorrhage or respiratory defects, severe crushing of the extremities, incomplete amputations, severe lacerations and open fractures.

3. Delayed Injuries—20%—*Second Priority*. Includes closed fractures, moderate lacerations without extensive bleeding, second and third degree burns that are mild and noncritical central nervous system injuries.

4. Expectant Care — 20% *Last Priority*, with a very low salvage rate. Includes critical central nervous system injuries, abdominal and chest injuries, severe burns and multiple severe wounds.

To survive as an individual, we should remember the following general principles:

1. With warning—close all doors and windows. If possible, back them up with blankets, bedding or heavy furniture or anything that will prevent glass from scattering.

2. Seek cover under a bed or any substantial object. If outdoors, seek cover in a ditch or anything that throws a shadow on you; or any area where there will be at least 3 ft. of dirt between you and the burst.

3. Drop flat on your stomach. Keep your face down and count off at least 20 seconds. Don't be curious.

4. Don't rush outdoors.
5. Remain calm and don't run wildly about.
6. Don't take chances with food and water.
7. Get official information from your Conalrad Station. 640 or 1240 on your radio dial.

In conclusion, a few general facts may be of interest—

1. A surface burst of a nuclear weapon includes radioactive fallout, in addition to blast and thermal effects.
2. Simple shielding may block the thermal effects of the burst and prevent a severe burn.
3. Fox holes and properly designed shelters may afford good protection against blast effects.
4. Radioactive Fallout (and 90% of radioactivity is lost in the first seven hours), is like dust and "rolls off." Thus, removing clothing and washing with soap and water removes 95% of the radioactivity. Foods that are covered are safe and can be used when the radioactivity material is washed off and the can or box opened carefully.
5. It has been shown that no chronic psychoses are due to or the result of a disaster. There is tremendous amount of stress because of fear of loss of life, loss of stature or fear of multilation. Panic, or uncontrolled fright, can be avoided when the people are educated and are taught how to cope with a disaster in that they have a knowledge of first aid and the security of knowing that they may survive.

Reprinted from The Bulletin Dade County Medical Association, June 1961.

Papers for Annual Meeting

The Committee on Scientific Work requests that members desiring to present papers at the Association's Annual Meeting May 9-13, 1962, submit an abstract prior to November 20. Those planning scientific exhibits should submit a short description to the Committee at P.O. Box 2411, Jacksonville 3.

AIDS TO PRACTICE

Questions and comments on appropriate economic and practice management problems are invited for publication in this column. Answers to your questions will be provided by a panel composed of various Florida members of the Medical-Dental-Hospital Bureaus of America.

Question: I hear it soon will be legal to incorporate my medical practice. What remarks would you make on the significance of this to Florida physicians in individual private practice?

Answer: Among the primary advantages to physicians suggested by advocates of this new Florida law is the possible federal income tax savings resulting from pension and tax deferment plans set up under the corporate form. It is hoped that physicians will have an equal opportunity with owner-employees of business corporations to establish and maintain retirement programs acceptable to the Internal Revenue Service. For years corporations have been allowed to set aside relatively modest amounts, treated as current operating expense to reduce taxable income, under certain regulations and conditions, for retirement payments to employees. Corporation owner-employees, however, are not taxed on these contributions to the plan until they receive the retirement income.

For medical partnerships and groups this law may well do for Florida doctors what the Kintner plan and the Keogh bills have not been able to accomplish. There is some feeling by at least one member of the panel, however, that the individual practitioner should proceed slowly toward use of the new law. The incompatability between the basic characteristics of the "corporate being" and the individual medical practice may not be acceptable to the IRS, particularly as other states are hastening to pass similar laws, and this could represent a big bite out of internal revenue currently. Why not let some other doctor provide the testing ground! Meanwhile, discuss the subject thoroughly with your attorney and tax advisor.

Question: Have there been any important changes in the current version of the Keogh bill in Washington, and what are its chances of passage into law this year?

Answer: On May 9 the House Ways and Means Committee gave formal approval to H.R. 10, the Keogh bill, offering self-employed individuals the tax benefits of contributions to "qualified" pension and profit-sharing plans. Contributions to the plan would be deductible from current income, as current operating expense, and income earned on these contributions would not be taxed until funds are withdrawn. Doctors would be able to get coverage even though they are not subject to social security self-employment taxes. Where an owner-employee, (a sole proprietor or a partner with more than ten per cent captial or profits interest), special rules would apply. For instance, benefits must not begin before age 59½, but must begin before age 70½. The rules vary between the owner-employee who has more than three full time employees and the man with no more than three. The deductible contribution for the doctor with three or fewer employees would be the lesser of 10 per cent of practice earnings or $2,500.00. Men with more than three employees could exceed this ceiling. What are the chances of becoming law now? Slight, we judge, in light of Washington's increased needs for arms spending.

Question: What is the best procedure to follow to protect my fee on a deceased patient?

Answer: Prompt efforts should be made to identify and contact the person who is responsible for the deceased patient's bill. This may be a husband, or the father of a minor child, who, merely by his relationship, is responsible for the fee. Or, it may be some other relative or a non-relative who is the guarantor. Such a guarantor perhaps cannot be held to his responsibility unless the commitment is in writing. If the foregoing cannot be accomplished, check with the probate court of your county to see if there is an estate filed. Your claim against the estate must be filed within eight months of the time the estate is filed for probate. If there is no estate, try to establish the liability and resolve manner of payment as soon after death as possible.

Question: Have "collections" dropped off recently for Florida physicians?

Answer: Conditions affecting collection of fees differ widely in various sections of the state; for example, between primary tourist and non-tourist sections. For this reason, no categorical answer can be given. Your local Medical-Dental-Hospital Bureau can give you their experience on the local level. But first, cast a jaundiced eye upon your front office to be sure your billing and follow-up routines have not suffered a recent setback!

REPORTS

American Medical Association 110th Annual Meeting

Osteopathy, medical discipline, communications, surgical assistants, drug legislation, general practice residencies, relations with allied health professions and services, and poliomyelitis vaccine were among the major subjects covered by 115 resolutions and 28 reports acted upon by the House of Delegates of the American Medical Association at its 110th Annual Meeting held June 25-30, 1961, in New York City. Dr. George M. Fister of Ogden, Utah, a member of the Board of Trustees and previously a member of the House of Delegates, was named president-elect of the Association. Dr. Fister will become president at the June 1962 annual meeting in Chicago, succeeding Dr. Leonard W. Larson of Bismarck, N.D., who assumed office at the Tuesday night inaugural ceremony in New York. Dr. Homer L. Pearson Jr. of Miami was elected to the Board of Trustees and was succeeded on the Judicial Council by Elmer G. Shelley of North East, Pa. Total registration reached 64,679, including 23,083 physicians.

The House of Delegates voted to present the 1961 Distinguished Service Award to Dr. Walter H. Judd of Minneapolis, physician and member of the Congress, for his contributions as a medical missionary, humanitarian and statesman devoted to world peace. Dr. Frederick J. Stare, chairman of the Department of Nutrition at Harvard Medical School, received the 1961 Goldberger Award in Clinical Nutrition.

Osteopathy

In considering a report of the Judicial Council and three resolutions on the subject of osteopathy, the House of Delegates agreed with the intent of the report and resolutions, but instead adopted the following statement of policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to reappraise its application of policy regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical."

Medical Discipline

In a major move designed to strengthen the profession's disciplinary mechanisms, the House approved the conclusions and recommendations of the Medical Disciplinary Committee, with only three word changes. The House discharged the committee with thanks and commendation and directed that its functions be assumed as a continuing activity of the Judicial Council.

One recommendation suggests that "The by-laws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level."

Another "encourages and urges that each state association report annually to the American Medical Association all major disciplinary actions taken within its jurisdiction during the preceding calendar year."

The report urged state and county medical societies to utilize grievance committees as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member.

The House suggested that each medical school develop and present a required course in ethics and socioeconomic principles, and that each state board of medical examiners include questions on ethics and proper socioeconomic practices in all examinations for license.

The report concluded with a recommendation that "American medicine at the national, state and local level maintain an active, aggressive and continuing interest in medical disciplinary matters so that, by a demonstration of good faith, medicine will be permitted to continue to discipline its own members when necessary."

Communications

Acting upon four resolutions related to the Association's public relations program, the House adopted a substitute resolution directing the Speaker of the House of Delegates to name seven elected members of the House as a special committee "to study and continually advise the Board of Trustees on the broad planning and coordination of all phases of communications of the American Medical Association, so that the public and the members of the medical profession are properly and adequately advised of the policies and concern of the medical profession with respect to all phases and aspects of medical care for all people."

Surgical Assistants

The House approved the following five basic principles developed by the Judicial Council and the Council on Medical Service on the subject of surgical assistant's fees:

"1. Each member of the A.M.A. is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"4. It is ethically permissible for a surgeon to employ other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance.

"This principle applies whether or not an assisting physician is the referring doctor and whether he is on a per-case or full-time basis. The controlling factor is the status of the assisting physician. If the practice is a subterfuge to split fees or to divide an insurance benefit, or if the physician is not actually employed and used as a bona fide assistant, then the practice is contrary to ethical principles.

"5. Under all other circumstances where services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately."

Efficacy of Drugs

The House strongly endorsed a Board report which pointed out the problems that would result from amending the Food, Drug and Cosmetic Act to authorize the Food and Drug Administration to determine the efficacy, as well as the safety, of a prescription drug prior to the approval of a new drug application. The American Medical Association will oppose such legislation before the Kefauver Committee, the report pointed out, on the basis that "a decision with respect to the effectiveness of drugs is dependent upon extended research, experimentation and usage."

General Practice Residencies

On the subject of creating new two year, residency training programs in general practice, the House approved a substitute resolution directing the Council on Medical Education and Hospitals to consider for approval, in addition to the currently existing Family Practice Program, other two year programs in general practice which incorporate experience in obstetrics and surgery. The Council will review these programs on the basis of their individual merits and conduct a long range evaluation of the new programs as well as the previously established Family Practice Program.

Relations with Other Health Professions and Services

The House approved the establishment of a new Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services. The Commission will correlate and catalogue the reports of the subcommittees and will act as liaison agent between the subcommittees and those Councils where there may be overlapping interests.

Polio Vaccine

Approving a report by the Council on Drugs on the present status of poliomyelitis vaccination in the United States, the House urged that it be made available to all physicians through the most effective communications media. The report clearly outlines procedures recommended for implementation of mass vaccination with the new oral vaccine when it becomes available and provides the practicing physician with a reliable series of answers to the many questions which will arise during the change-over from Salk vaccine to oral vaccine. It emphasizes, however, that "physicians should encourage, support and extend the use of Salk vaccine on the widest possible scale at least until the oral polio-virus vaccines currently under development and clinical trial become available."

Miscellaneous Actions

In dealing with resolutions and reports on a wide variety of other subjects, the House approved the "Guides to Physician Relationships with Medical Care Plans," submitted by the Council on Medical Service, with two changes. It reaffirmed its support of the Kerr-Mills program for the needy and near-needy aged and its opposition to any legislation of the King-Anderson type, declaring that the medical profession "will not be a willing party to implementing any system which we believe to be detrimental to the public welfare." It also approved a markedly expanded drug information program, adopted the final report of the Special Study Committee of the Council on Medical Education and Hospitals, decided to hold the 1963 Clinical Meeting in Portland, Ore., and approved a plan by the Association's Department of International Health to cooperate in the recruitment of volunteer physicians for emergency medical service in foreign mission fields.

In addition, the House agreed to an increase of $20 in the annual membership dues to be implemented over a period of two years: $10 on Jan. 1, 1962, and $10 additional on Jan. 1, 1963. It also discontinued the Association's General Practitioner of the Year award, opposed legislative and administrative mandates which would compel physicians to prescribe drugs, or require pharmaceuticals to be sold, by generic name only, reaffirmed the Association's opposition to compulsory inclusion of physicians under the Social Security system, urged immunization campaigns against both tetanus and influenza, and asked state and county medical societies to give full support to the First National Congress on Medical Quackery to be sponsored jointly next October 6 and 7 in Washington, D. C., by the American Medical Association and the Food and Drug Administration.

Leaders Speak

At the opening session on Monday, Dr. E. Vincent Askey of Los Angeles, retiring president, challenged physicians and medical organizations to re-examine their own efforts to strengthen and improve medicine, and he warned against defeatism and failure to accept personal responsibility for answering criticisms. Dr. Larson, then president-elect, called on the profession to strengthen methods of self discipline in both the state and county societies, adding that physicians must be concerned with improper or incompetent practice and unethical actions of all kinds. In his inaugural address on Tuesday night, he said that the really good doctor, guided by the professional spirit, will always remember that medicine exists for just one purpose—to serve humanity. When the essence of that spirit is diluted or destroyed, either in an individual physician or in a nation, he added, medicine ceases to be a profession in the highest sense of the word.

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NEWS & PERSONALS

Dr. William M. Rowlett of Tampa, following the June meeting of the American Medical Association in New York, went to England where he attended a conference of the delegates of the British Medical Association at Sheffield.

The color motion picture "Man Returns to the Sea" produced by Dr. G. Dekle Taylor of Jacksonville has been selected for exhibition at international film festivals being held at Venice, Berlin, Edinburgh, Stratford and Vancouver. The film is one of a group of 46 non-theatrical films selected by the Committee on International Non-Theatrical Events as an American entry in the festival.

Dr. Edward R. Annis of Miami was principal speaker at a meeting of the Knoxville (Tenn.) Academy of Medicine on July 19. On August 1, Dr. Annis addressed a meeting of the Chattanooga and Hamilton County Medical Society at Chattanooga, Tenn. On July 17, he was in Jacksonville where he was principal speaker at a meeting of the Rotary Club of that city.

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Drs. George H. Garmany of Tallahassee and Alpheus T. Kennedy of Pensacola have been appointed as members of the State Board of Medical Examiners by Governor Farris Bryant.

Dr. Andrew E. Lorincz of Gainesville, Assistant Professor of Pediatrics at the University of Florida College of Medicine, was in Europe during August where he lectured in various medical schools and research institutions. He presented a paper at the Fifth International Congress of Biochemistry held in Moscow.

Dr. Perry A. Sperber Jr. of Daytona Beach has been made a Fellow in the American Association for the Advancement of Science in recognition of his research work and publications in the field of medicine.

Dr. Robert J. Brown of Jacksonville has been elected to the Board of Directors of the Jacksonville Blood Bank. Dr. Brown is secretary of the Duval County Medical Society.

The University of Miami School of Medicine has received $184,698 in new and renewal grants from the National Institutes of Health. The funds have been allotted to research programs in medicine, surgery, cardiology, cancer and virus research being conducted by Drs. William L. Pond, Ulfar Jonsson, Robert J. Boucek, Robert S. Litwak, Frank Gollan and Paul W. Boyles.

Dr. James R. West of Lakeland was among the group of Florida physicians attending the recent Mountain Top Medical Assembly held at Waynesville, N. C.

Dr. J. Champneys Taylor of Jacksonville presented two addresses at the Southern Obstetric and Gynecologic Seminar held July 17-22 at Asheville, N. C. On July 18, Dr. Taylor discussed "Marriage Counseling" and on the final day of the Seminar, participating in the program on office gynecology, he discussed "Artificial Insemination."

Dr. M. Eugene Flipse of Miami, Professor of Medicine at the University of Miami School of



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Medicine, served as chairman of the program committee which developed the four day symposium sessions and arranged the bilingual translation at the Third Inter-American Conference on Occupational Medicine held in Miami August 6-10. Assisting with other arrangements was Dr. Milton M. Coplan of Miami.

Dr. F. Gordon King of Jacksonville attended the surgical section meetings of the Texas Medical Assembly held at Houston in July.

Dr. Fred E. Manulis of Palm Beach, governor for Florida of the American College of Gastroenterology, has announced that the Annual Course in Postgraduate Gastroenterology presented by the College will be held at the Sheraton-Cleveland Hotel in Cleveland on October 26-28.

Dr. Mason Romaine III of Jacksonville has announced that three faculty members of the University of Florida College of Medicine have been given grants totalling $23,760 which will be used to conduct research on diseases of the heart and blood vessels. They are Drs. Richard T. Smith, Melvin J. Fregly and Clyde M. Williams. Dr. Romaine is president of the heart association.

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MEETINGS

The 22nd annual meeting of the American Fracture Association will be held September 16-23 at the Shoreham Hotel in Washington, D. C.

Dr. John A. D. Cooper will be installed as dean of the University of Miami School of Medicine this fall. At present, he is associate dean of Northwestern University Medical School, and also professor of biochemistry. Dr. Cooper had undergraduate work at the University of New Mexico and graduate study in biochemistry and medicine at Northwestern. He was awarded the Ph.D. degree in 1943 and the degree in medicine in 1951.

September

Florida Society of Anesthesiologists, Sept. 16-17, The Carosel, Daytona Beach

Seminar in Neurology, Sept. 28-30, College of Medicine, University of Florida, Gainesville

October

Florida Academy of General Practice, Oct. 6-8, Hotel Diplomat, Hollywood

Florida Psychiatric Society, Oct. 21-22, Grand Bahama Hotel, West End, Grand Bahama Island

Seminar in Orthopedic Surgery, Oct. 26-28, College of Medicine, University of Florida, Gainesville

November

2nd Postgraduate Medical Seminar Cruise, Nov. 2-12, S. S. Hanseatic, College of Medicine, University of Florida, Gainesville

Florida Urological Society, Nov. 3-5, The Inn, Ponte Vedra, Fla.

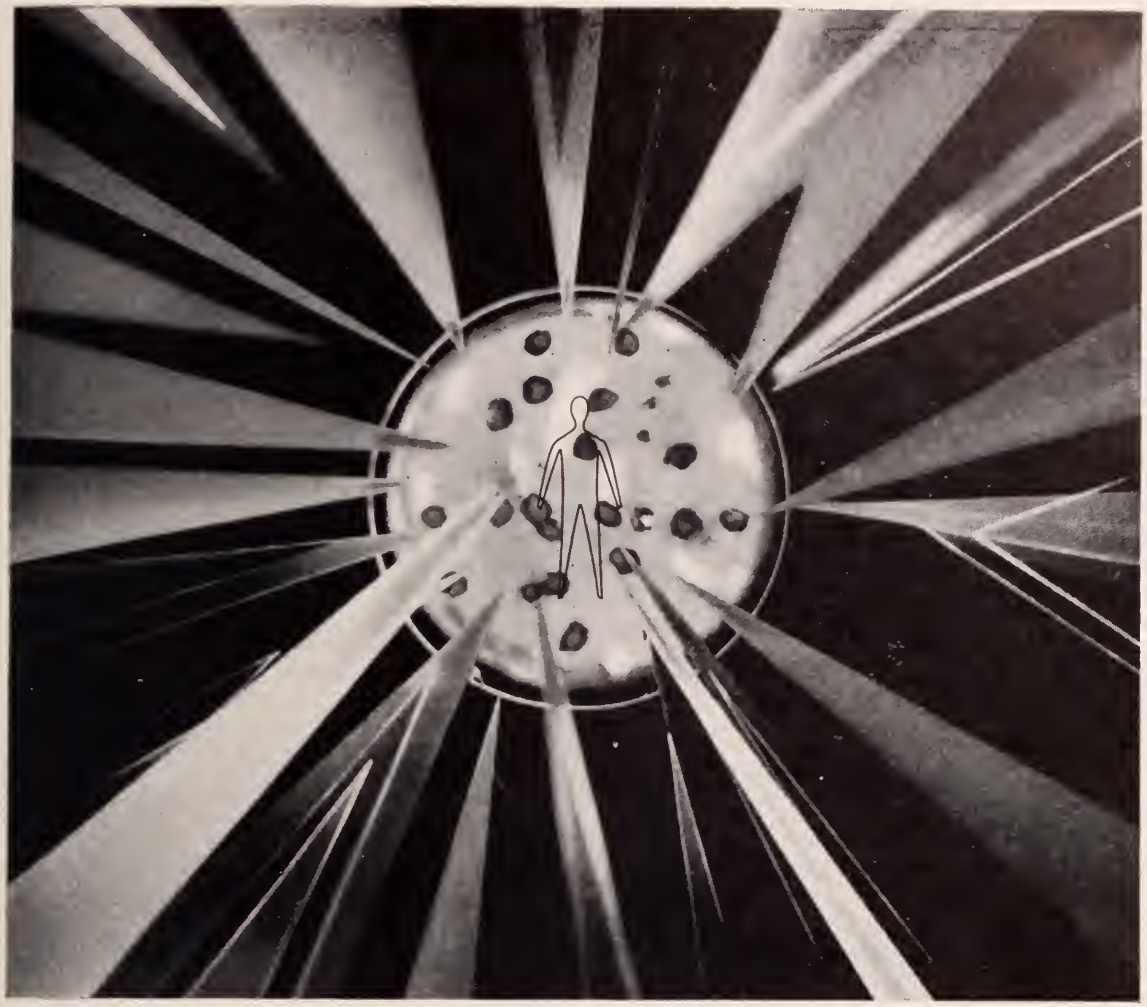
Florida Pediatric Society, Nov. 9-12, Cherry Plaza Hotel, Orlando

December

Florida Obstetric and Gynecologic Society, Dec. 1-3, Gault Ocean Mile Hotel, Fort Lauderdale

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OBITUARIES

Andrews, Laurin L., Avon Park; George Washington University School of Medicine, Washington D. C., 1910; engaged in the general practice of medicine in Dade County from 1937 until several years before his death when he retired to Avon Park because of impaired health; was a founder of the hospital which has since become Hialeah Hospital; member of the American Academy of General Practice and a charter member of the Florida Academy of General Practice; died February 16, aged 87, of coronary thrombosis.

Barney, Burton F., Palm Beach; University of Michigan Medical School, Ann Arbor, Mich., 1931; member of the American Medical Association, Southern Medical Association and American Dermatological Association; practiced dermatology in West Palm Beach for 14 years, coming there from Columbus, Ohio, where he had practiced for 11 years; died May 19, aged 56, after an extended illness.

Brantley, Grady H., Lake Worth; born in Lawrenceville, Ga., on Dec. 10, 1889; Georgia College of Eclectic Medicine and Surgery, Atlanta, Ga., 1916; interned at Georgian Hospital in that city; veteran of World War I; engaged in the general practice of medicine in Lake Worth for more than 40 years and served as mayor from 1939 to 1945; member of the American Medical Association and the Southern Medical Association; died February 9, aged 71 years.

Brown, Edwin H., Green Cove Springs; born in Sharon, Pa., on Nov. 7, 1911; Vanderbilt University School of Medicine, Nashville, Tenn., 1937; interned and served a residency in general surgery at the Duval Medical Center in Jacksonville; staff member in general practice at the Clay County Memorial Hospital; member of the Southern Medical Association and the American Medical Association; died April 15, aged 49.

Gill, Euclid Borland, Fort Lauderdale; born in New Orleans, La., in 1900; Tulane University School of Medicine, New Orleans, 1923; interned

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Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

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at Charity Hospital, New Orleans; was Clinical Assistant in Pediatrics at his alma mater for two years; engaged in the general practice of medicine in New Orleans until 1946, in Fort Lauderdale until 1953, in Leesburg until 1955 and in Fort Lauderdale again from 1955 until his death; veteran of World War I; member of the American Medical Association; died May 8, aged 60, after a long illness.

Grace, William H., Fort Myers; son of Dr. George M. Grace, born at Graceville, Dec. 18, 1881; Tulane University School of Medicine, New Orleans, La., 1906; practiced in Chipley until 1924 when he located in Fort Myers; member of the American Medical Association, Southern Medical Association and American Academy of General Practice, fellow of the American Geriatrics Society, and past president of the Tulane Alumni Association; honored in 1956 for 50 years of service to medicine by his alma mater and by the Lee County Medical Society, which he served for several terms as secretary and president; died March 23, aged 79, of pulmonary infarction and phlebothrombosis.

Mitchell, George Alfred, Coral Gables; born in Osceola, Mo., in 1910; St. Louis University School of Medicine, St. Louis, 1936; served an internship at the St. Louis University Hospital Group and in 1940 completed a residency there; entered the private practice of obstetrics and gynecology in Miami in 1940; a founder member and immediate past president of the medical staff of Doctors Hospital and a director of its John T. McDonald Foundation; veteran of World War II; member of the American Medical Association, the American College of Surgeons and the Southern Obstetrics and Gynecology Society; died March 5, aged 50 years.

Paty, Philip B., Dunedin; born in Soochow, China, Jan. 5, 1926; Emory University School of Medicine, Atlanta, Ga., 1952; member of the American Heart Association and a fellow of the American Geriatrics Society; cardiologist at Mease Hospital, where he died May 5, aged 35.

Roche, Thomas W., Jacksonville; born in Miami Beach on Feb. 21, 1924, the son of Dr. Charles F. Roche, one of the first physicians to

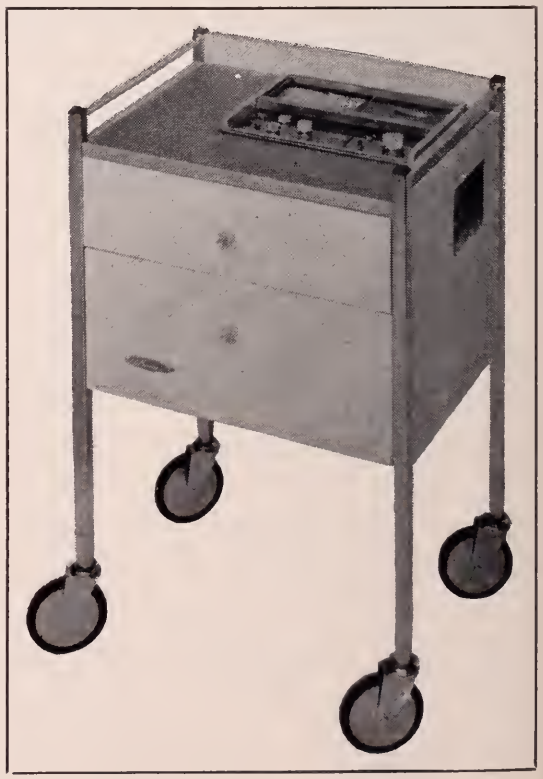
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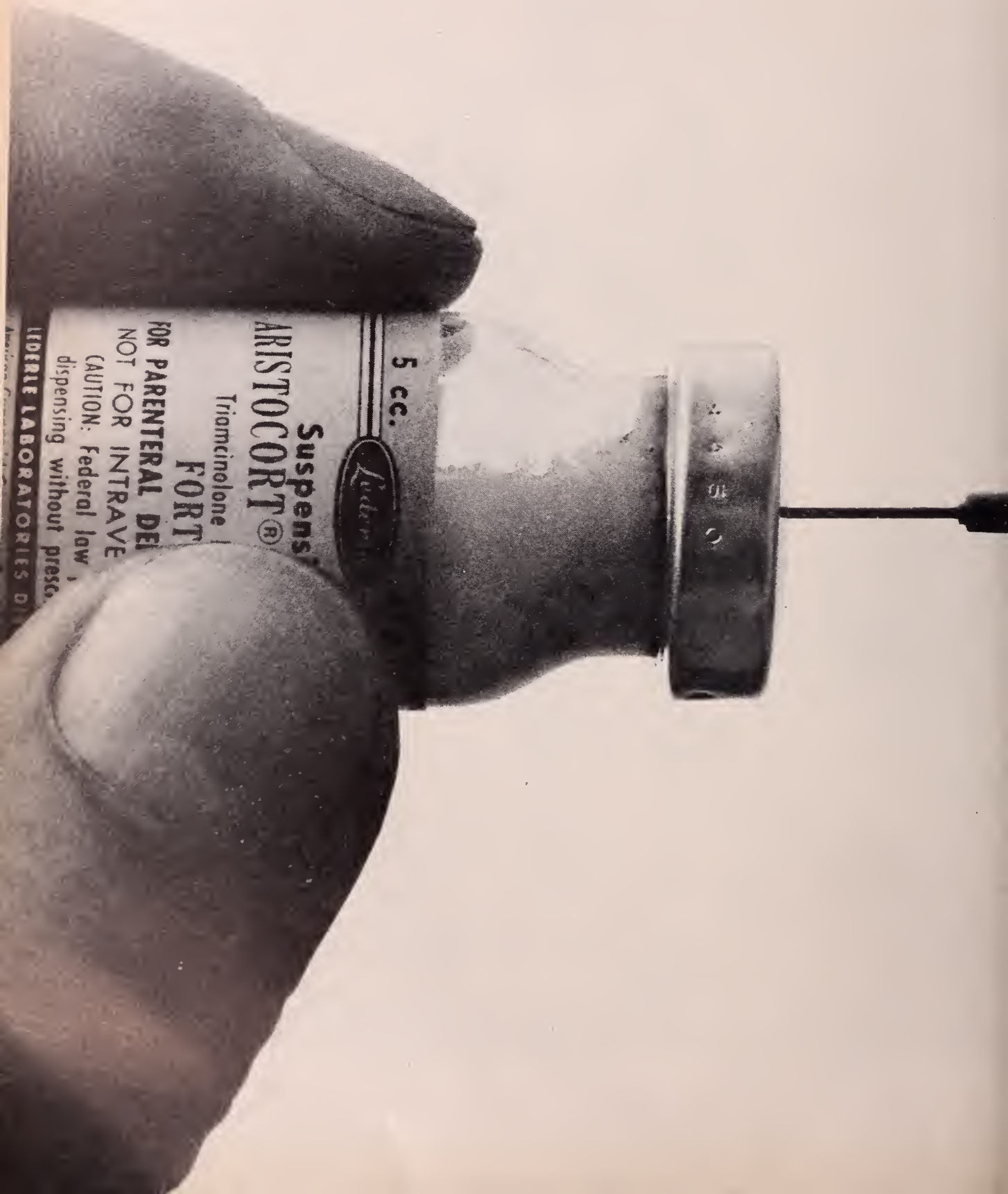
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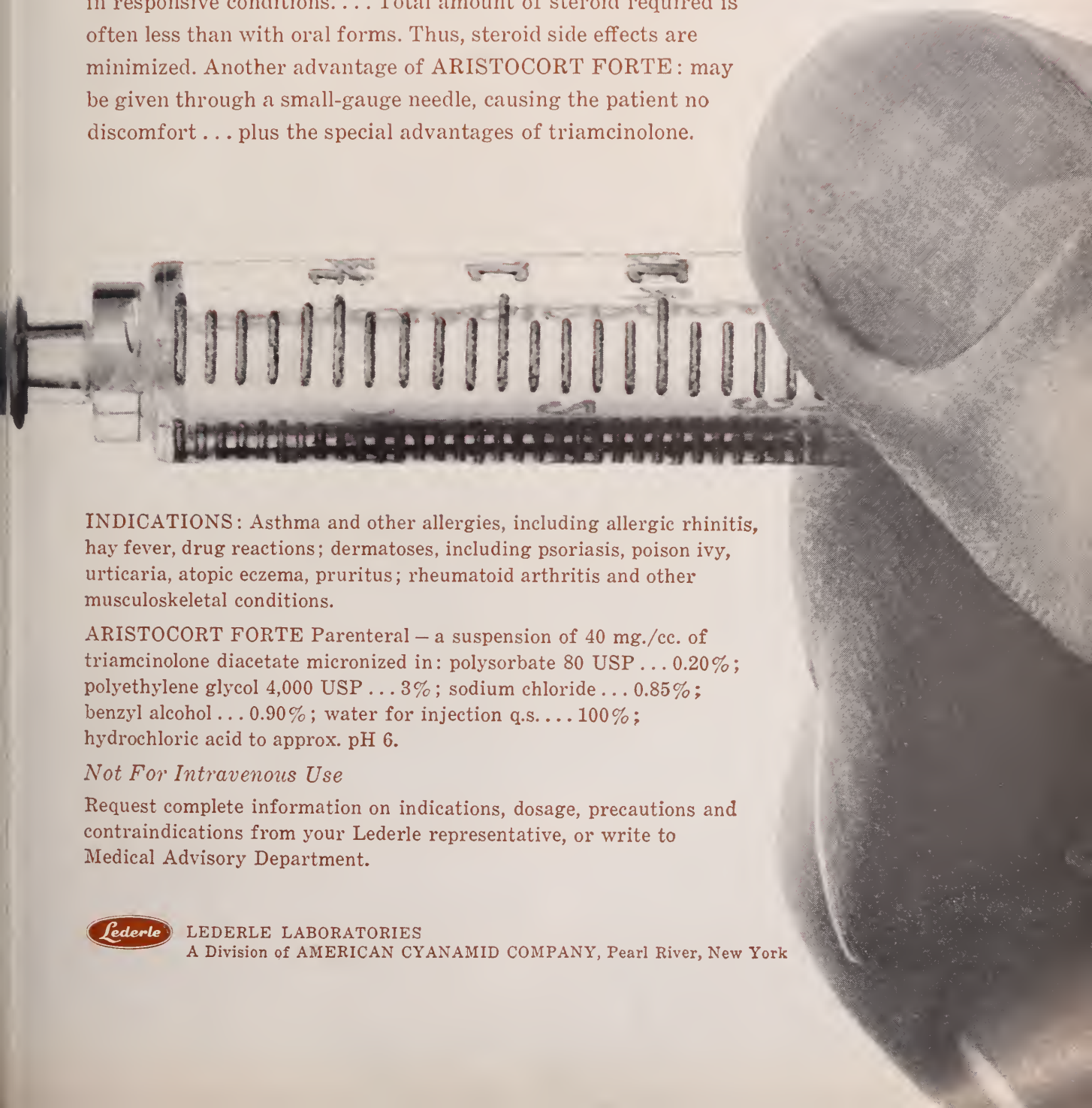
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(Continued from page 276)

practice there; University of Michigan Medical School, Ann Arbor, Mich., 1953; interned at the University of Virginia Hospital, Charlottesville, Va.; served residencies at Mercy and Victoria hospitals in Miami and St. Francis Hospital in Miami Beach; engaged in the general practice of medicine in Miami Beach for five years; served as a voluntary instructor on the faculty of medicine of the University of Miami School of Medicine; veteran of World War II, member of the American Medical Association; located in Jacksonville in February 1960; died Dec. 5, 1960, aged 36.

Walters, Arthur Louis, Miami Beach; born in Battle Ground, Ind., in 1884; Johns Hopkins University School of Medicine, Baltimore, 1912; gained national recognition as Director of Research Laboratories for Eli Lilly & Company for his original work in the development and production of insulin; came to Miami Beach in 1925 as Director of Medicine at Allison Hospital, later St. Francis Hospital, where he served for years as president of the staff; member of the American Medical Association, the National Diabetic Association and the American College of Physicians; member of the Committee on Publications of The Journal for a number of years; died January 26, aged 77 years.

Wylie, LeRoy A., Bradenton; born in Lynn, Mass., in 1885; New York University College of Medicine, New York City, 1911; entered the practice of surgery in St. Petersburg in 1920; was a founder of Faith Hospital, which later became St. Anthony's Hospital; veteran of both World Wars; after World War II, spent four years in Washington with the Bureau of Medicine and Surgery; life member and past president of the Pinellas County Medical Society; member of the American Medical Association; moved to Bradenton upon retirement in 1950; died March 4, aged 75 years.

Williams, William C. Jr., Delray Beach; born in Twiggs County, Ga., 1887; Atlanta School of Medicine, 1911; general practice at Cary, Ga., until September, 1925; medical officer World War I; former state senator and member Georgia Board of Medical Examiners; located in Delray Beach in 1925; additional training Edward Hines Veterans Hospital; returned to West Palm Beach in 1935 for practice of urology and surgery; retired in 1958; died June 13; aged 74.

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*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

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Reports from our representatives indicate that many physicians would appreciate simplification for prescription-writing purposes of the names of Terramycin products in both the "plain" and the "Cosa" dosage forms.

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Cosa-Terrabon Pediatric Drops	**Terramycin** Pediatric Drops

and simpler names for these Terramycin-containing formulations:

Cosa-Terrastatin® Capsules	**Terrastatin**® Capsules
Cosa-Terrastatin for Oral Suspension	**Terrastatin** for Oral Suspension
Cosa-Terracydin® Capsules	**Terracydin**® Capsules

. . . and these names remain unchanged:
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The Ciba Foundation, supported and initiated by the Swiss Ciba company, organizes periodically small conferences in which informal discussions are held between research workers of different disciplines and different nationalities, some of the conferences lasting three or four days, others only one day. The proceedings of the former are published in book form, the Ciba Foundation Symposia, and the latter in the Study Group booklet series. With rapid printing and distribution of the proceedings of both conferences and study groups, the foundation makes an invaluable contribution to scientific development. Through these publications readers in the most distant centers, away from easy reference to the latest literature, can feel more closely in touch with recent developments and current work and may thus be stimulated to make their own contribution in topics of international research significance.

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complex first presented by Henri in 1902, later applied to enzyme kinetics by Michaelis and Menten in 1913, had been advanced by Emil Fischer who suggested in 1894 that enzyme and glycoside must fit each other like a lock and its key in order to react with one another. The study of the stereospecificity of enzymes has given us, together with the use of isotopes, insight into the mechanisms of enzyme reactions, the basis for all of life's processes. Pasteur had found a special yeast which ferments the ammonium salt of dextrorotatory tartaric acid, but does not act upon the levorotatory form of the acid. He presented his discovery as ". . . an excellent method of preparing levo-tartaric acid." One century later McMenamy and Oncley (1958) found that while L-triptophan is strongly bound to serum albumin, the D-form has less than one hundredth the affinity of the L-isomer. These and many other exciting facts of current interest are discussed by the participants and their verbatim statements and many illustrations provide an up-to-date understanding and information on the subject. This session was held in honor of Prof. Dr. V. Prelog, from Zurich.

C. P. L.

Treatment of Urinary Lithiasis. Compiled and edited by Arthur J. Butt, B.S., M.D., F.A.C.S. Pp. 577. Illustrated. Price $21.00. Springfield, Ill., Charles C. Thomas, Publisher, 1960.

Here is a text that should be in the library of every specialist in urology. Never has this subject been more carefully outlined and illustrated in such concise and legible form. The author, a Floridian, has chosen 31 responsible co-authors to create this authoritative contribution to the medical field. Being interested in medical history, I carefully scrutinized the first chapter and found it to be as exact as history permits. Though the urologist should benefit more by reading the text, all medical practitioners would do themselves no harm to peruse its contents. The script is in large print and scientifically written in a simple understanding manner. Photographs of techniques, specimens, x-rays, drawings and charts are extremely clear and illustrative. The genitourinary stone is attacked from every possible angle and it does not have a chance to survive in living tissue with this array of experienced and competent investigators and clinicians aiming their research and medical and surgical armentaria at it. Though I am in a distant specialty, I enjoyed reading every page of this current literature.

Clifford C. Snyder, M.D.

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The Office Assistant In Medical Practice. By Portia M. Frederick and Carol Towner. Ed. 2. Pp. 407. Illustrated. Price, $5.25. Philadelphia, W. B. Saunders Company, 1960.

Doctor, have you had to "break in a new girl recently?" Or have you wondered how you could improve the efficiency of that secretary-nurse you have employed for the past five years? If you are a busy man and have this added burden, The Office Assistant In Medical Practice will be worth its weight in gold to you. This book is written from the secretary-nurse's point of view and in language she can easily understand. The authors discuss in detail the many facets of the career as medical office assistant such as Medical Ethics and Medico-legal Affairs —what your assistant must and must not do or say lest she ethically or legally entangle you with your colleagues or patients; how to receive patients, keep them happy while waiting, make them want to "pay cash" and send them away with a smile on their face; the art of the pleasant and adequate yet succinct telephone conversation; the technique of making appointments and keeping the office on schedule; the taking and filing of records; the essentials of bookkeeping, banking, and insurance forms; that ticklish problem of billing and collecting; and her duties as your medical assistant—preparing the patient for examination, assisting in such procedures as routine examinations, pelvic examinations and rectal examinations; sterilization techniques and the proper care of instruments and syringes. Finally, the authors discuss the general care of the office and housekeeping and that very important subject—the purchasing of supplies. This reviewer knows from personal experience that the busy physician cannot find the time to instruct his new assistant in all the varied details of office management and frequently must incur inconveniences and the threat of a serious mistake on her part while she is learning. Here is a book by two well qualified instructors that his assistant can understand and which will greatly shorten her training period and prepare her for that unexpected emergency situation the physcian forgot to mention.

William M. Straight, M.D.

Women and Fatigue. *A Woman Doctor's Answer.* By Dr. Marion Hilliard. Pp. 175. Price, $2.95. Garden City, N. Y., Doubleday & Company, Inc., 1960.

"But, Doctor, why am I so tired?" This was the question most frequently asked Dr. Marion Hilliard, former chief of obstetrics and gynecology at Women's College Hospital in Toronto. In this book, Dr. Hilliard, author of the best selling book, "A Woman Doctor Looks at Love and Life," has again displayed her ability to help readers discover the self knowledge which leads to inner peace and successful, productive lives. Here she probes both the physical and emotional causes of fatigue. She points out that each person's metabolism is different and that individual capacities to adapt to environmental stresses vary. Even without excessive stress, women are naturally subject to certain kinds of fatigue, especially during the periods of greatest glandular change—adolescence, pregnancy, and menopause. Dr. Hilliard also clarifies the psychological aspects of fatigue—worry, tension, feelings of loneliness or inadequacy, and many other contributing factors. Above all, she presents real and practical solutions to the problem of fatigue, solutions which help every woman to understand her feelings, to conquer her tiredness, and to accept her hereditary limitations with grace. With this positive approach, the book becomes a useful guide to greater health.

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Obstetrics. By J. P. Greenhill, M.D., F.A.C.S., F.I.C.S. (Hon.). Ed. 12. Pp. 1098. Illus. 1219 on 903 figs., 119 in color. Price, $17.00. Philadelphia, W. B. Saunders Company, 1960.

This beautifully executed volume, from the original text of Joseph B. De Lee, M.D., presents an up-to-the-minute picture of obstetric practice with practical guidance for the obstetrician, general physician and medical student. In this new completely revised twelfth edition, practically all of today's essential knowledge about obstetrics may be found. Every aspect of the field is covered, from clear description of conception through the course of pregnancy and delivery to circumcision of the newborn. Effective care at every stage is detailed—immediate treatment of unexpected difficulties; prevention of accident and infection; relief of discomfort; management of various disease states concurrent with pregnancy. Over 100 pages are devoted to clear explanation of the mechanisms of labor and another 100 pages to step-by-step procedures in delivery. Complications and pitfalls are well outlined. Dr. Greenhill and his 23 distinguished collaborators have bent every effort to include definitive information on the many recent advances in endocrinologic, nutritional, psychologic and other aspects of pregnancy and the puerperium. Every page has been rewritten, 162 new illustrations have been added and important new data, concepts and techniques have been added to the various sections.

Diseases of the Skin. By James Marshall, M.D. (Lond.). Pp. 952. Illus. 652. Price, $15.00. Edinburgh and London, E. & S. Livingstone Ltd., 1960. The Williams & Wilkins Co., Baltimore, exclusive U. S. agents.

An important feature of any book on skin diseases is an abundance of photographs to illustrate the very nature of the conditions described in the written contents. The author has supplied these, though all of them are in black and white. Histopathological examination is an asset to most texts, but especially in one of this sort. Dr. Marshall describes, when possible, the microscopic findings of the lesions in his book. There is an entire chapter devoted to local and general therapy including the corticosteroids, antibiotics, fungicides, x-ray, dry ice and diathermy. Some of the conditions studied are more common in other parts of the world than our country, but this does not alter the book. The abstracter recommends this good text on skin diseases to men in general practice and to medical undergraduates. The dermatologist would not be benefitted as much because of repetition in his education, though there is a bibliography for advanced study and reading.

Clifford C. Snyder, M.D.

Management of Hypertensive Diseases. By Joseph C. Edwards, A.B., M.D., F.A.C.P., F.A.C.C. Pp. 439. Illustrated. Price $15.00. St. Louis, The C. V. Mosby Company, 1960.

This new, well documented guidebook to the practical and clinical management of hypertensive diseases summarizes the major developments in this exciting and fluid field and applies these findings in such a way that it becomes a particularly useful guide to individualized therapy. One of the few books written by an experienced and presently active clinician and educator, Dr. Joseph C. Edwards, this clinically oriented volume defines and discusses diagnosis, lists the types of arterial hypertension and separates them into those due to known and unknown causes. It devotes special attention to treatment, especially of the most commonly encountered primary idiopathic type of hypertension. Writes Dr. Paul Dudley White in the Foreword, "This book by Dr. Edwards presents clearly and succinctly the present status of the problem of hypertension and its treatment. Important details of the use of the potent drugs alone and in combinations are included." Case presentations show the clinical findings, laboratory data and kind and doses of drugs used with actual blood pressure responses shown.

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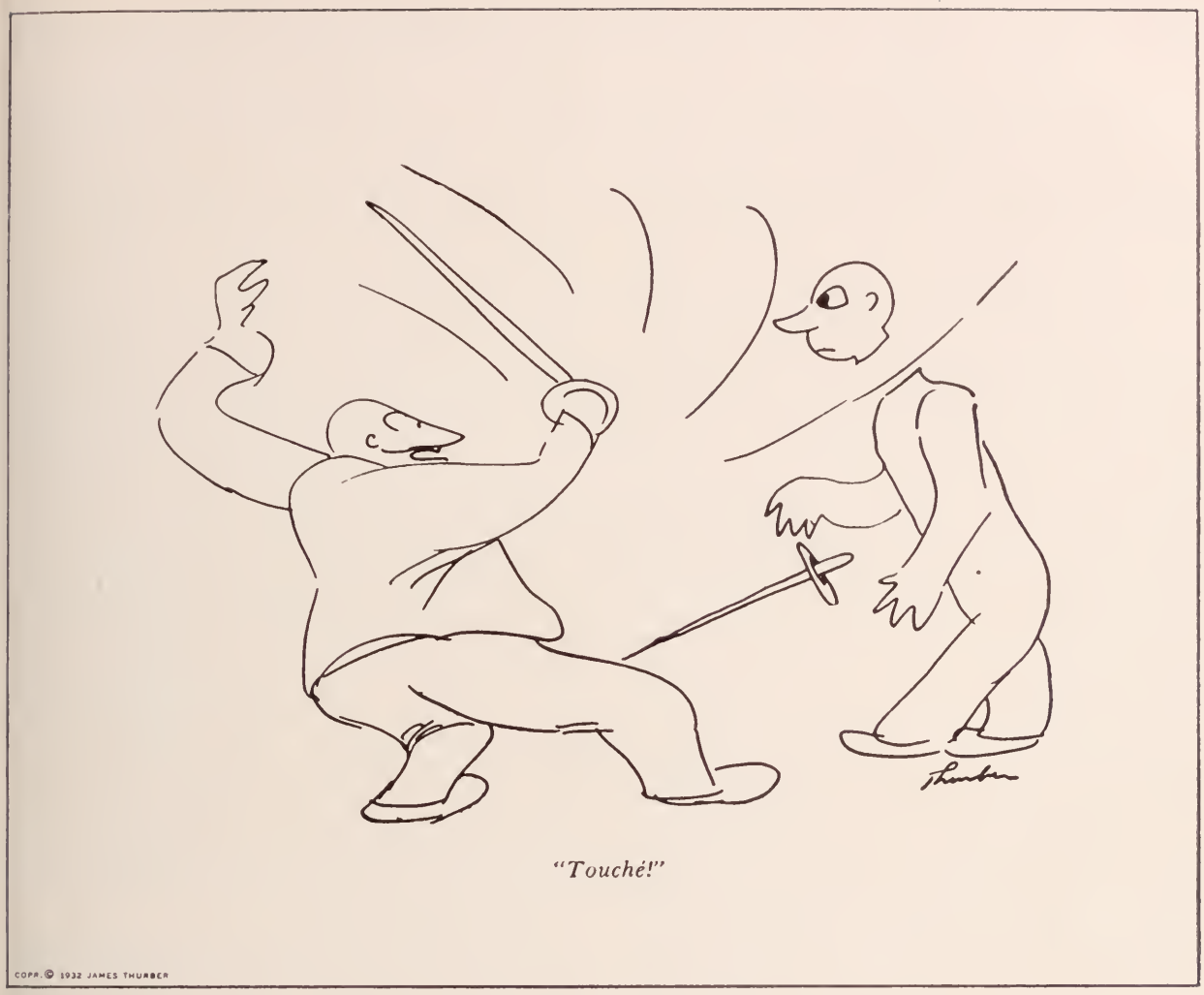
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Rudolph Matas. A Biography of one of the great pioneers in surgery. By Isidore Cohn, M.D. with Hermann B. Deutsch. Pp. 431. Price, $5.95. Garden City, N. Y., Doubleday & Company, Inc., 1960.

Reading the lives of the great pioneers should be a required subject in general education. In Medicine in particular, it is often indispensable to know of the lives and the works of the great pathfinders in order to understand how our present knowledge has been achieved. A practicing physician who treats diabetic patients without having read the history of Banting and Best, and of the many who preceded them in the quest for the cause and the treatment of diabetes, cannot have a full understanding of what he is doing and will be less successful than those who are fully familiar with the step by step course of the events which led to the discovery of insulin. A vascular surgeon of today acquires a greater understanding and respect for his own work after he learns of the conditions which led Rudolph Matas to discover the first way to treat an aneurysm successfully.

Being an inveterate reader of biographies, this reviewer has enjoyed a real field day with this book. It reads more like an historical novel, the difference being that all characters and events depicted were real and many are still living. Dr. Matas was born at Bonne Carre, 50 twisting miles north of New Orleans, Sept. 12, 1860 and died in New Orleans on Sept. 23, 1957. He was the son of a Catalonian physician-adventurer who made a fortune in shady deals during the Civil War and went back to Spain with his wife and little boy at the end of the war. He later lived in Paris for some time, and when the money was gone, the family returned to New Orleans. Soon after the birth of a sister the parents separated, the adventurous father going away in search of new fortunes.

The boy had mastery of Spanish, Catalonian and French as well as his native English, and an inquiring mind together with a photographic memory. He became a brilliant student and in 1879 was sent to Havana as a member of the first Yellow Fever Commission of the National Board of Health to investigate the etiology of the terrible epidemics of yellow fever which every summer ravaged New Orleans and other Gulf ports and was endemic in Havana. Young Matas had become adept at photography and at handling the microscope specially built for this mission by Karl Zeiss, in Jena, at that time the world's foremost lens maker. The trip was a failure; the cause and mode of transmission of yellow fever were not found then.

While in Havana Matas became very friendly with the corresponding secretary of the Cuban Academy of Medicine, a tall, angular, stoop-shouldered physician, peering near-sightedly through gold-rimmed spectacles, Dr. Juan Carlos Finlay, who had been appointed a member of a local auxiliary commission. As a parting gift Matas gave Dr. Finlay a complete set of the many photographs and microphotographs of patients and their tissues which the Commission had studied during the fruitless search. Within two years after the Commission's departure from Havana, Finlay declared on the basis of experiments undertaken after a close study of these photomicrographs that the dread disease was spread by the sting of the female Culex mosquito. Although practically no one in the United States or Havana or elsewhere would pay the least attention to him, Finlay's papers were dutifully translated and published in the New Orleans Medical and Surgical Journal by his friend Rudolph Matas, who was its editor for many years.

Two decades of fever epidemics were to pass before a second United States Commission would put the Mosquito Maniac's theory to the definitive test. Ever since that time the Cubans, who were the first to scoff at El Loco de los Mosquitos, have sought—and not always successfully—to counteract the impression that the discoverer of the mosquito's role in disseminating yellow fever was a North American named Walter Reed. Many years later, in 1941, and in recognition of being the world's first, foremost, and most consistent defender of Finlayism, Rudolph Matas received from Cuba's president the first award of the Finlay Medal.

The book covers, with an amazing amount of historical minutious detail, the life of Narciso H. Matas, the father of the biographee, his brilliant career as physician-ophthalmologist and seeker of the pot-of-gold, his unhappy marriage and his deep devotion to his even more brilliant son, expressed in numerous father-son correspondence. The friendship of Rudolph with Lafcadio Hearn, the famous poet and foremost "beatnick" of the nineteenth century; the one and only romance in the life of Dr. Matas and his patient wait of many years before he could marry the woman he loved, who had been abandoned by a first husband, are all part of the drama. Being Catholics, his mother would never have consented to see her son married to a divorcee. So they waited until the death of the first husband released her. This resulted in a most devoted and happy marriage marred only by the loss at birth of their only son.

The well over 400 pages of the book are filled with pathos, romance, history. In fact, if any criticism can be made against the authors, it is that their main character becomes almost obscured by the profusion of other very important characters with their detailed biographies and by so many details about the historical incidents that accompanied the life of Matas. It could almost be said that the book could have been entitled "New Orleans and Yellow Fever." Just the same, it is an absorbing book, enormously interesting and illuminating.

C.P.L.

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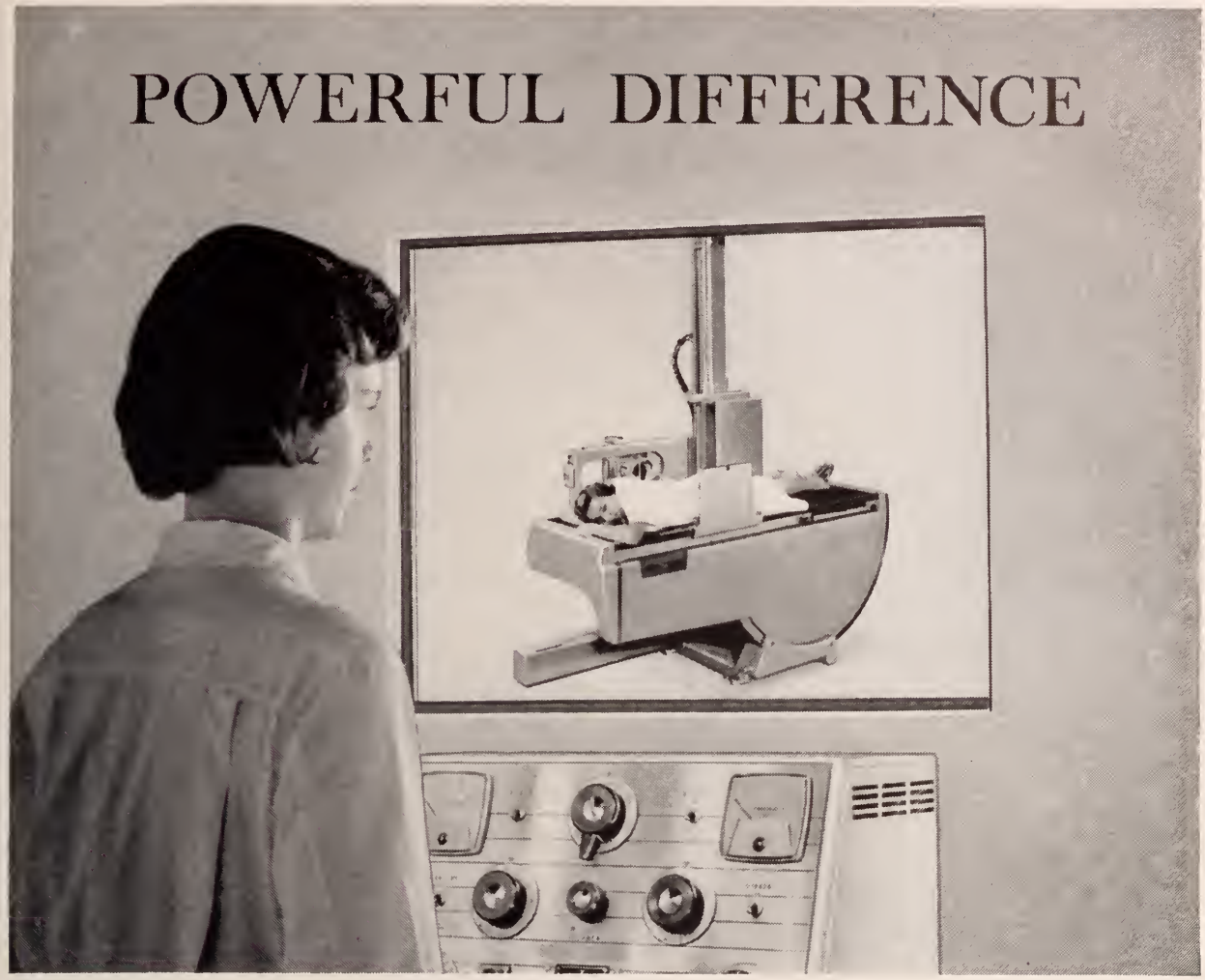
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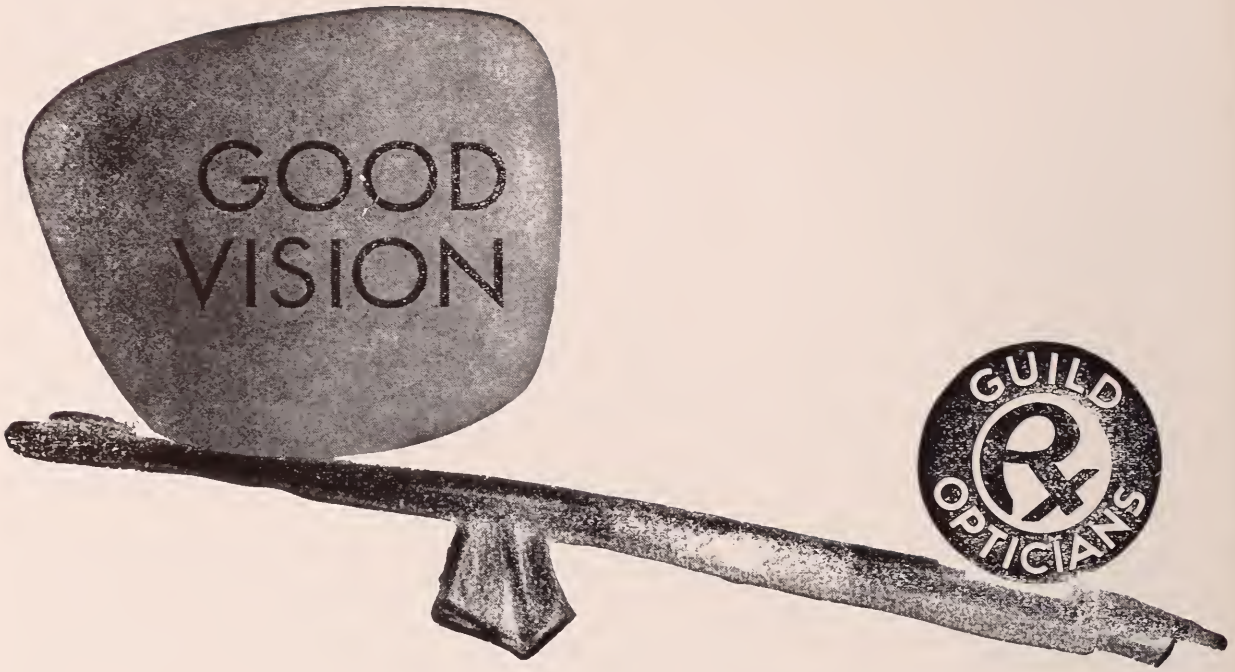
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(1) Buck, R. C.: Minerals of Normal and Arteriosclerotic Aortas, Arch. Path., 51, 1951. (2) N. Ressler, et al.: Relation of Serum Stability to the Development of Arteriosclerosis, Amer. J. Clin. Path. vol. 24, 1954. (3) S. D. Jacobson, M.D., Wayne County General Hospital, Eloise, Michigan. To be published. (4) Prof. V. Patzelt, Untersuchungen uber die Veranderunger der Bluteiweisz-Korper mit Mag. 3, 7-dimethyl-xanthine oleate, Klin. Med. 5, 11, 1956. (5) Dr. J. Skursky, Wiener Med. Wochenschrift, 1953, Nr 46, S. 886-887. (6) Eduard Keeser, M.D. and K. F. Benitz, M. D., Med. Klin. 1953 Nr. 15.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W. and Fong, T. C. C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition, W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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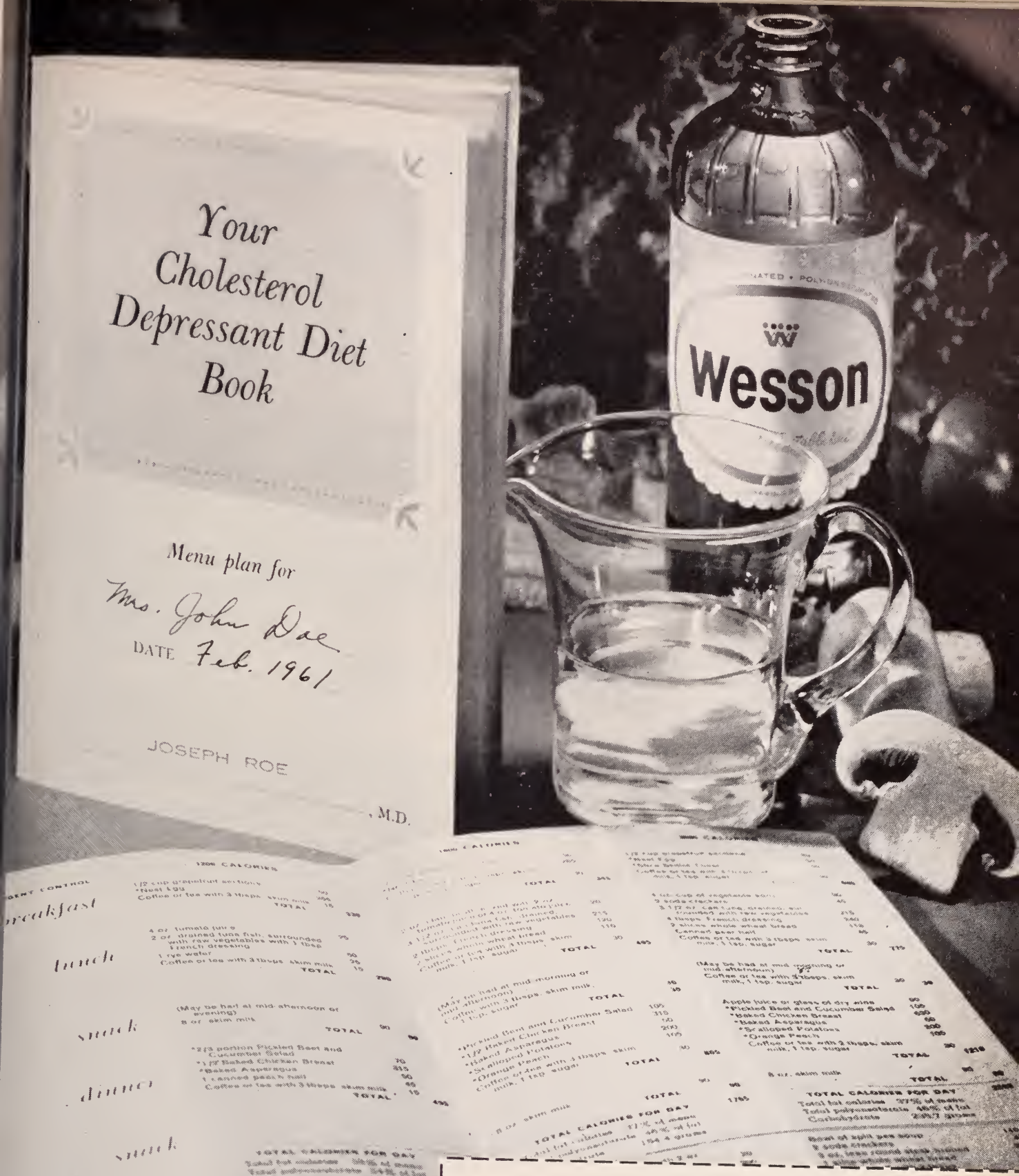
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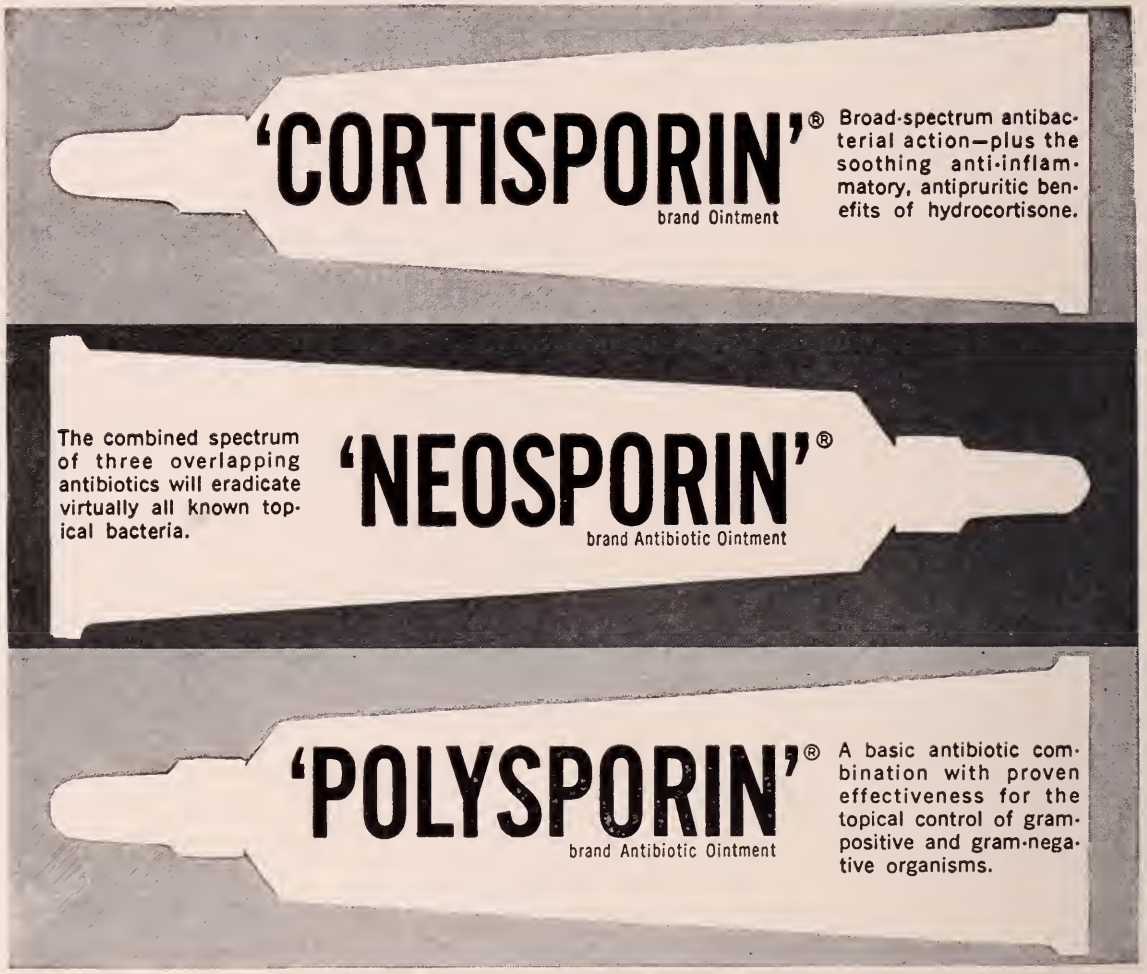
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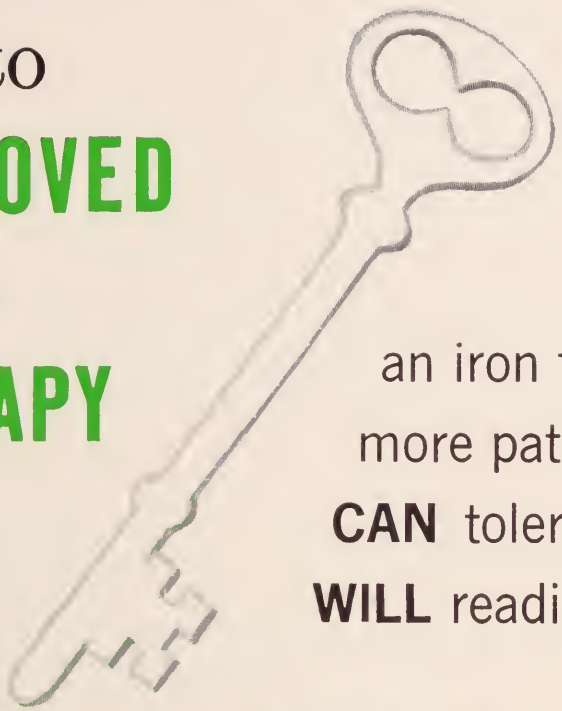
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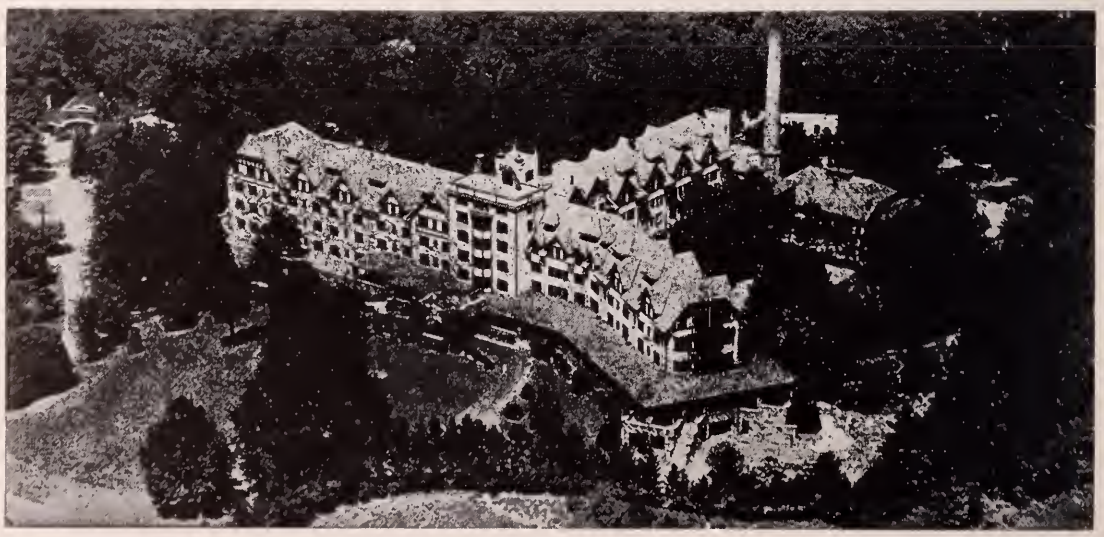
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., **et al.**: Diabetes 7:398, 1958.

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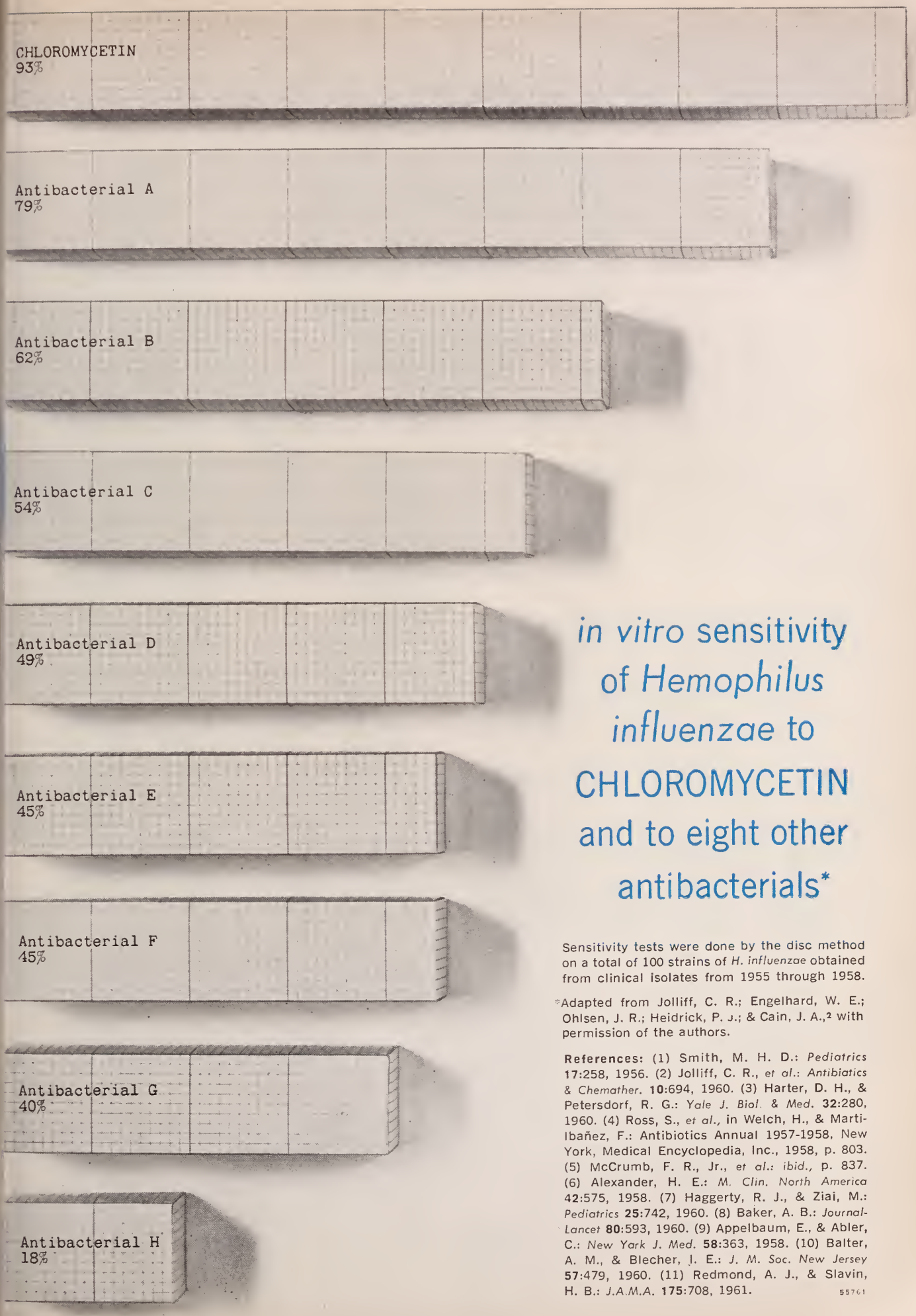
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Sensitivity tests were done by the disc method on a total of 100 strains of *H. influenzae* obtained from clinical isolates from 1955 through 1958.

*Adapted from Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J.; & Cain, J. A.,[2] with permission of the authors.

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• *October, 1961*

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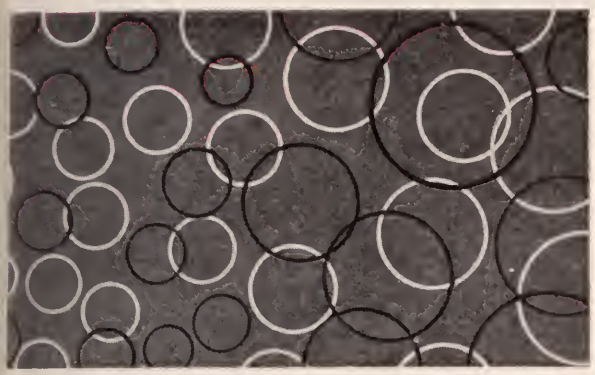
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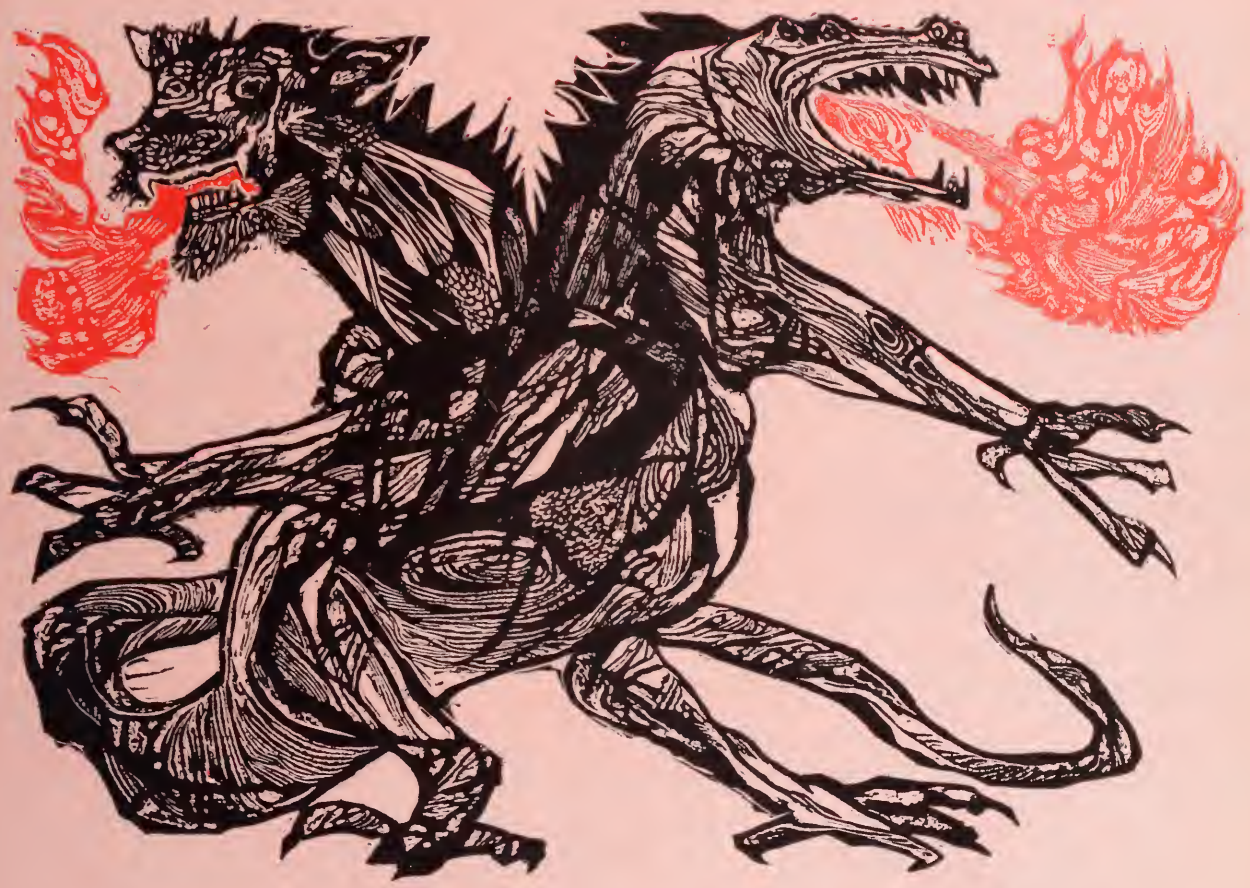
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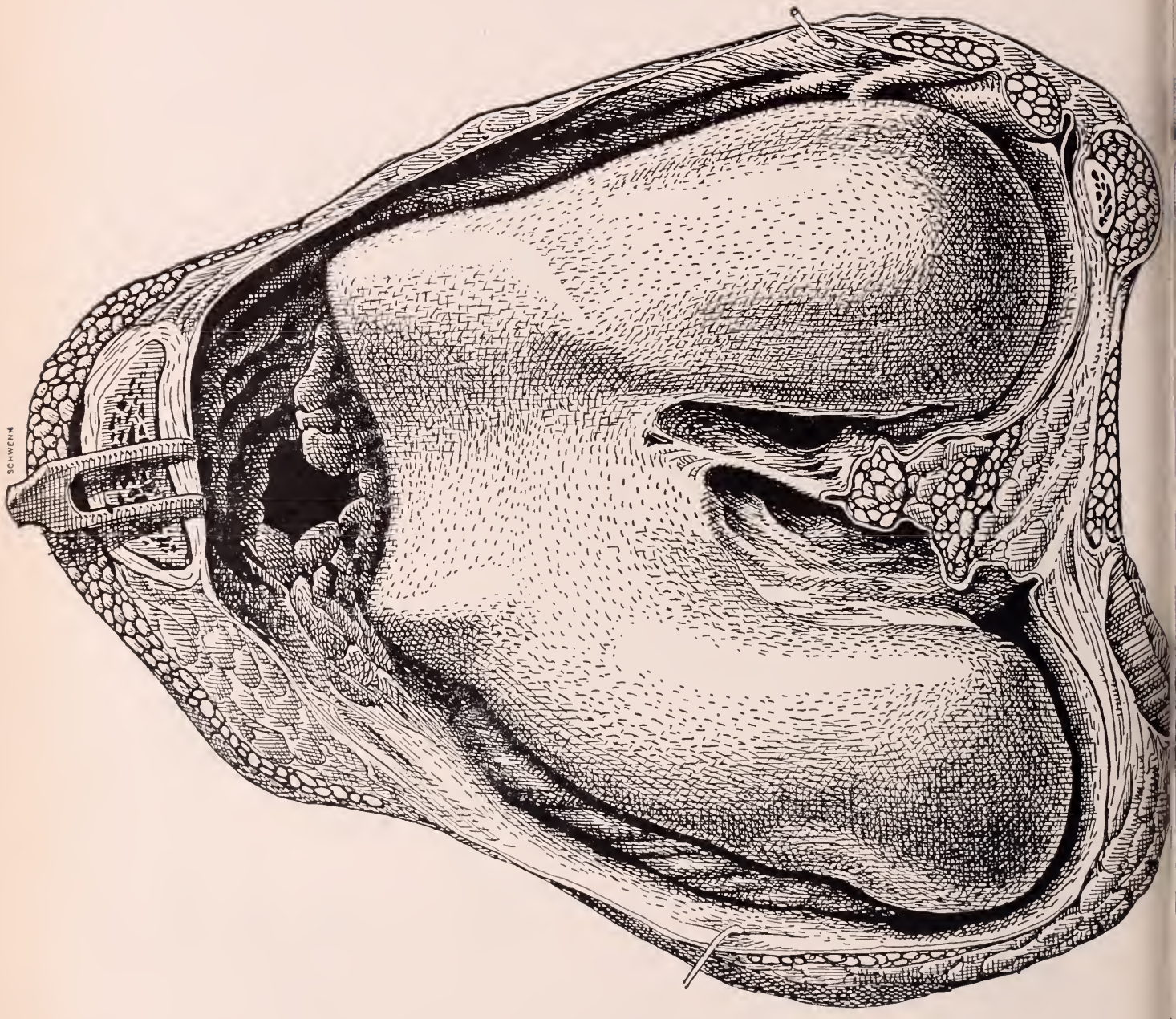
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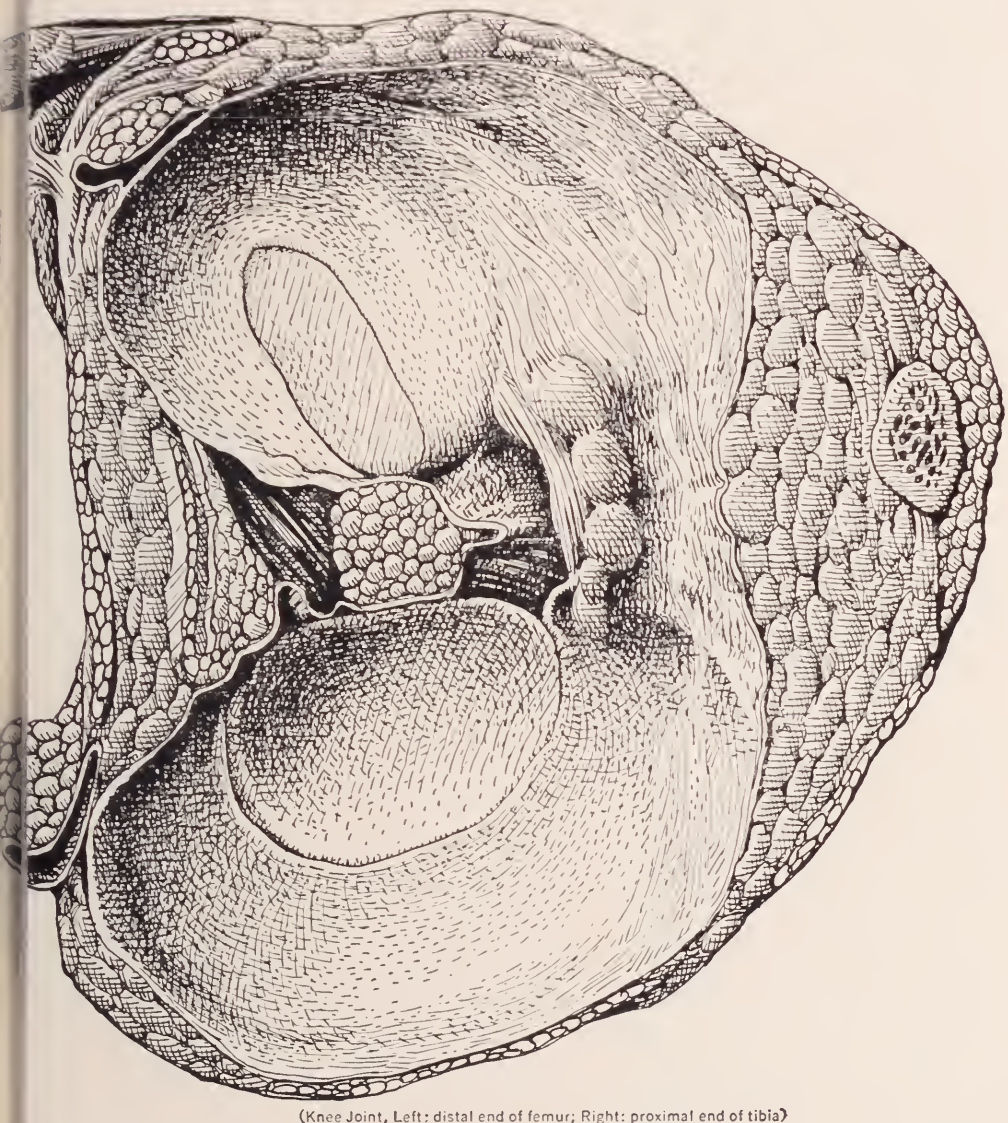
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THE JOURNAL
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Volume XLVIII, No. 4, October, 1961

A Brief Experience with Triparanol (MER-29)

WILLIAM M. STRAIGHT, M.D.
AND NEVIN C. LAHUIS, M.T.D.
MIAMI

The desirability of lowering blood cholesterol as a measure to combat atherosclerosis, although not of clearly proved value, is currently accepted. The inadequacy of dietary restriction of cholesterol and the presently known methods of enhancing cholesterol excretion are also generally known. Recently a new approach to the problem has been devised: the blocking of cholesterol biosynthesis in the liver. To accomplish this, a nonfeminizing estrogen analogue, triparanol (MER-29), has been introduced. Studies in animals[1] indicate this substance blocks cholesterol synthesis at the final step: conversion of 24-dehydrocholesterol (desmosterol) to cholesterol. The administration of this drug to animals produces a striking drop in both the blood and tissue cholesterol.[2] Administration of this compound to humans produced a statistically significant lowering of serum cholesterol (mean depression of 35 mg. per hundred cubic centimeters after one week and 58 mg. after four weeks of therapy in 36 patients) with minimal side effect.[3,4] This article is to report our experience with triparanol (MER-29)* administered to six private patients over a three month period and carefully followed by frequent laboratory evaluation of the blood lipids.**

Material

Six patients were selected at random from the private practice of one of us (W.M.S.), three of these being male and three female. Their ages were 28, 53, 60, 61, 77 and 79. All but one of these patients had evidence of arteriosclerotic cardiovascular disease. J. S. has had one bout of acute coronary insufficiency. J. D. has had one proved myocardial infarction. C. S. has had two myocardial infarctions and has moderately severe angina pectoris at rest. E. L. has coronary insufficiency proved by an exercise tolerance test though it is symptomatic only on marked exertion. E. S. has had two episodes of classical carotid artery insufficiency. W. S. is a 28 year old man who has hypertension, an elevated blood cholesterol, and a strong family history of hypertension and coronary occlusion. All of these patients had been under the observation of one of us (W.M.S.) at least six months prior to this experiment. All have been investigated for hypothyroidism, diabetes, renal and hepatic disease with negative results except for E. S., who had mild hypothyroidism in 1958 which is adequately controlled with thyroid extract and whose thyroid dosage has not changed during the past year.

Prior to the beginning of the control period, the patients were given written instructions in which each was urged to eat a diet low in animal fat. This was to be achieved by avoiding fatty meats, gravies, pork and pork products, butter, milk, cream and soft cheese. They were allowed to eat three or four eggs weekly and use oleomargarine as necessary. Fried foods were allowed if fried in vegetable oil. These instructions had been given to each patient many months prior to the onset of this experiment, but were repeated in letter form at the beginning of this study. One patient, J. S., who is cholesterol conscious, has for several years been restricting himself rigidly to a low cholesterol diet. He was asked to continue this diet so that we might note the results of this

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**Laboratory Studies by the LaHuis Clinical Laboratories, Miami.

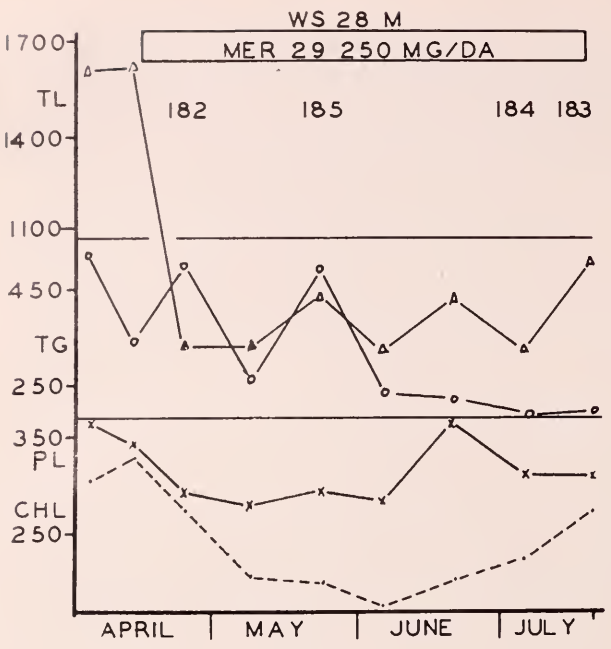


Figure 1

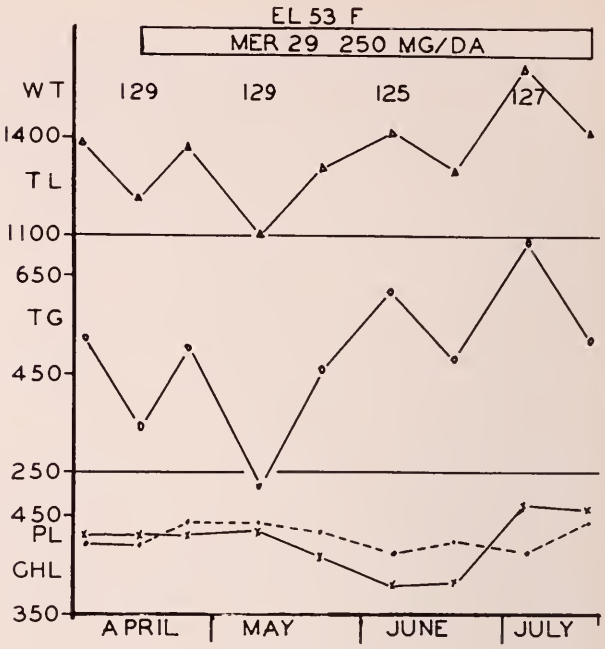


Figure 2

medication in a patient who rigidly restricts the cholesterol intake.

No attempt was made to restrict calories but, as will be noted on the graphs (figs. 1-6), throughout the experiment the body weights did not vary significantly. Each participant received ninety-six 250 mg. capsules of MER-29 and was instructed to take one capsule daily before breakfast. One patient, J. D., stated he missed two doses, and another, W. S., missed several doses, as he said he could not remember to take the capsule on Sunday morning. This same man was the only one known to be somewhat careless about his dietary intake of cholesterol; yet it will be noted he obtained one of the most striking responses. Only one of the six, J. S., was taking other medications known to lower blood cholesterol at the time of this MER-29 experiment. He had been taking Premarin, 0.3 mg. daily, and niacinamide, 50 mg. daily, for some months prior to the beginning of the experiment.

At approximately two week intervals blood samples were drawn and the weight determined on each patient at the laboratory. The chemical studies performed were: total cholesterol, phospholipids, triglycerides, total lipids, and phospholipid-cholesterol ratio. The methods used were: for the phospholipids, Fiske and Subbarow[5] and Bloor with several minor modifications; for the cholesterol, Carr and Drekter;[6] for the total lipids, de la Huerga, Yesinick and Popper;[7] the triglycerides were then determined by subtracting the sum of the phospholipids and cholesterol from the total lipids. The first two determinations taken at an interval of two weeks represent the control values, and were taken prior to the beginning of MER-29 therapy.

The patients were told only that this medication would lower the blood cholesterol, and no mention was made of side effects—good or bad. At the end of the experiment each was asked to recall whether he had encountered any side effects during the use of this medication. Four of the six patients had previously received various medications to lower blood cholesterol. J. S. has been taking Premarin and niacinamide for some time and has had numerous blood lipid studies in the past, establishing a good range and mean for each of these parameters (table 2). C. S., E. L. and E. S. have each been receiving nicotinic acid in doses of 3 Gm. daily with some response of the blood cholesterol. The onset, however, of burning, itching or tingling necessitated the discontinuance of nicotinic acid in the cases of C. S. and E. L. Although E. S. showed a moderate response to nicotinic acid, it produced considerable heartburn. Two of these had stopped taking nicotinic acid several months to a year prior to this present experience, and E. S. stopped taking it shortly before the beginning of the control period.

Results

The response of the blood cholesterol values for each patient is shown in table 1. The graphic results in each parameter of the blood lipids for each patient are contained in figures 1 through 6.

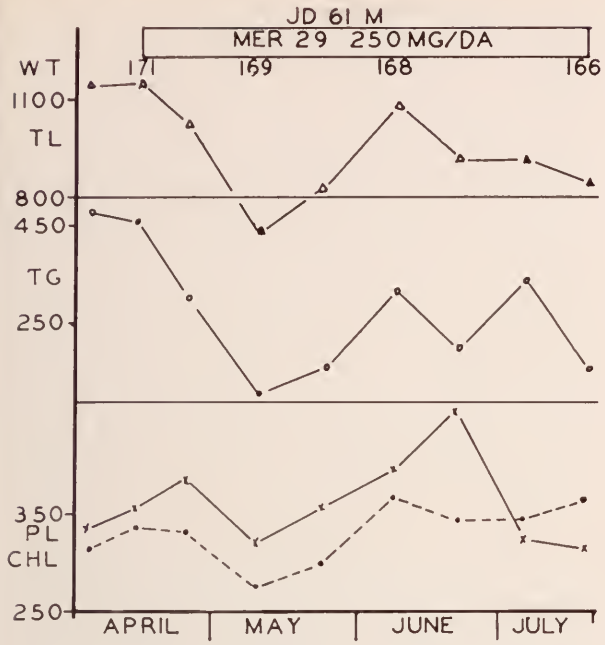


Figure 3

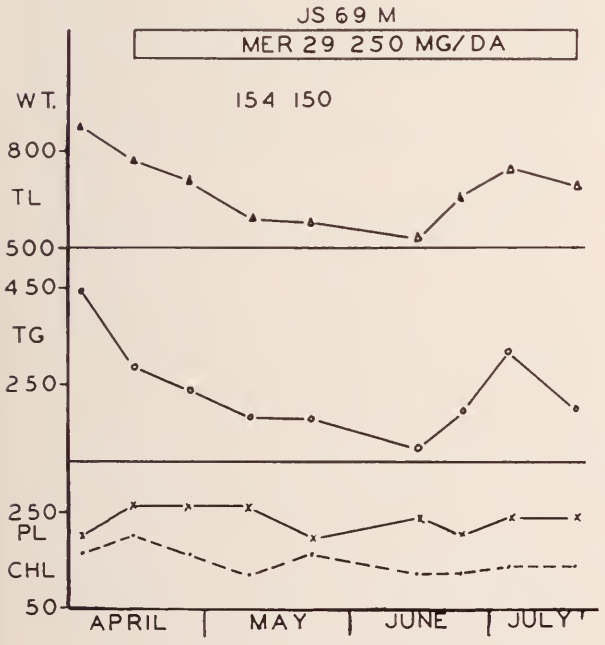


Figure 4

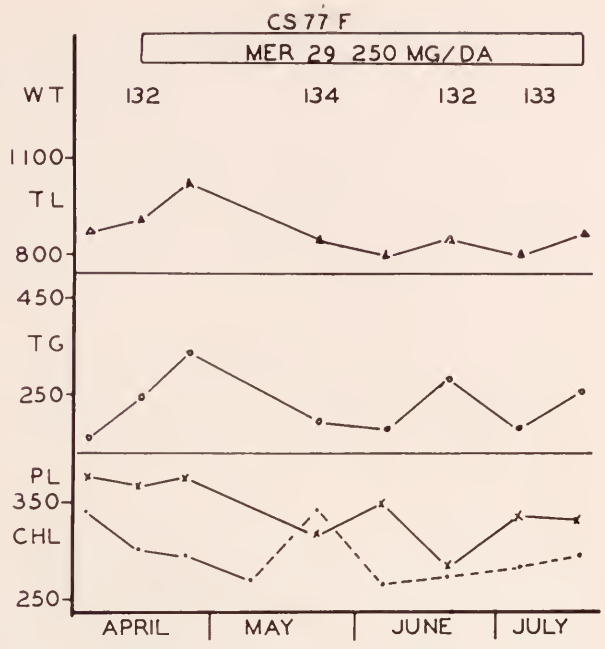


Figure 5

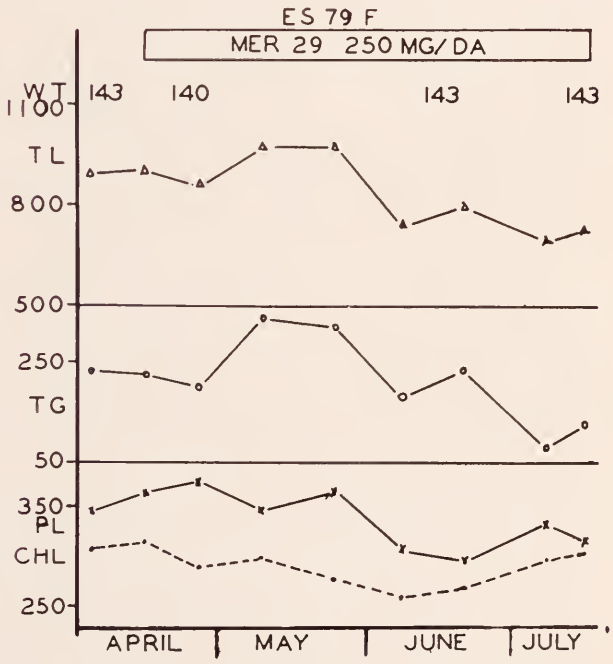


Figure 6

Table 1. — Analysis of Blood Cholesterol Values

Subjects	Previous Cholesterol Determinations			Cholesterol During MER-29 Therapy			Mean Control Cholesterol	Mean Change in Cholesterol	Per Cent Change in Cholesterol
	No. Det.	Mean Mg. %	Range Mg. %	No. Det.	Mean Mg. %	Range Mg. %	Mg. %	Mg. %	
J.S.	10	241	208-287	7	191	175-208	219	−28	12.8
W.S.	1	315	315	8	220	179-274	318	−198	62.2
J.D.	1	430	430	7	331	272-368	326	+5	1.5
C.S.	14	360	284-470	8	288	264-342	335	−47	14.0
E.L.	3	384	370-399	7	405	414-448	428	−23	5.4
E.S.	5	311	234-366	7	283	258-300	308	−25	8.1

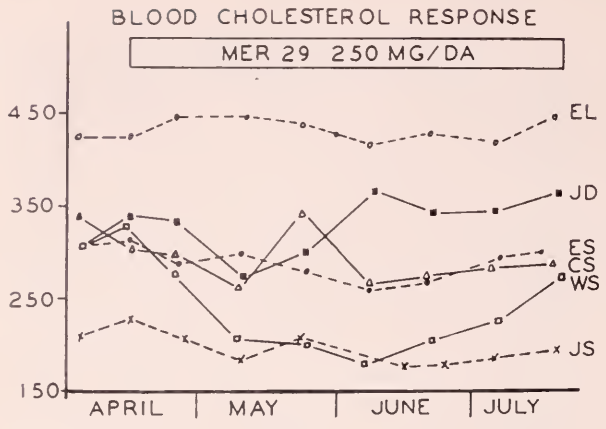


Figure 7

Figure 7 shows the superimposed curves of the cholesterol values alone in each of the patients. It will be noted that the blood cholesterol decreased strikingly in one patient, W. S., during the first two weeks of therapy, but toward the end of the experiment an upswing occurred. His was by far the best response with a mean decrease of 198 mg. per hundred cubic centimeters, or a drop of 62 per cent below the control level. Although the response was not nearly so great in the other patients, four of them showed mean decreases from control levels ranging from 23 to 47 mg. (5 to 14 per cent.) In one of these, E. S., there was a clear terminal upswing while the others varied up and down. The remaining patient, J. D., showed a mean increase of 5 mg. while taking the MER-29. The phospholipids varied in no clear relationship to the cholesterol, but generally remained unchanged despite the decreases in the cholesterol level.

Triglycerides showed a striking initial drop in three patients (J. D., J. S., W. S.) followed by a terminal rise which in one reached the previous level. Wide fluctuations occurred in this parameter, but this seems to be a common observation of others even under control conditions. During the six months prior to MER-29 therapy while on a rigid diet, niacinamide and estrogens, J. S. had complete blood lipid studies in the same laboratory used in this investigation (table 2). His triglyceride values ranged from 433 mg. to 747 mg. during this period. The total lipids, which are the sum of the triglycerides, phospholipids and cholesterol, varied in the direction of the predominant components. The striking drop from the control level as noted in W. S. raises the possibility of laboratory error, but these values were rechecked and essentially the same values were obtained. In the case of J. S., on whom we had extensive previous studies (table 2), drops occurred in all parameters during MER-29 administration as follows: cholesterol 12.8 per cent, total lipids 23 per cent, phospholipids 0.4 per cent and triglycerides 44.7 per cent.

Discussion

Although we report a small sample treated for a short period of time and no sweeping conclusions are justified, it was thought worth while to report our results since this sample was carefully studied and is typical of the ambulatory population of the physician's office. We have failed to obtain the dramatic decrease in blood cholesterol levels reported by some of the previous investigators.[3, 4, 8] The responses we observed were similar to those noted by Waddell[9] and Rosenman and Friedman.[10]

Several authors have reported increased exercise tolerance during MER-29 administration.[3,10-12] Our one patient with clearly symptomatic angina, C. S., had considerably more than her usual amount of pain during the month of May and early June. On continued administration of MER-29, however, she has become relatively free of angina and notes much less palpitation than was formerly present. Our other patient with angina, E. L., has pains so infrequently that it is not possible to draw any conclusions. J. S., who is asymptomatic but has had a positive exercise tolerance test since 1957, shows no improvement of the exercise test after four months of MER-29 therapy. Dietary restriction of fat is thought to be unnecessary for the achievement of good response,[13] and indeed our patient who ex-

Table 2.—Analysis of Chemical Studies on J.S.

Determination	Previous Studies			During MER-29 Therapy			Mean Control	Mean Change	Per Cent Change
	No. Det.	Mean Mg. %	Range Mg. %	No. Det.	Mean Mg. %	Range Mg.%	Mg. %	Mg. %	
Cholesterol	10	241	208-287	7	191	175-208	219	−28	12.8
Phospholipids	9	259	220-311	7	242	222-257	243	−1	0.4
Triglycerides	8	585	433-747	7	198	170-311	358	−160	44.7
Total Lipids	8	1081.2	904-1256	7	630	530-740	819	−189	23.0

hibited the most striking response, W. S., was the one who was most careless about his diet. He was, however, also the youngest of the group, which could possibly be a factor in his response. The relation of the age to the response achieved with MER-29 has not been investigated to our knowledge, and possibly with aging there are changes in the metabolic pathways which make them less easily altered by this or other medications affecting cholesterol biosynthesis.

No untoward effects were encountered in our small group during this three months of MER-29 administration. Two of the patients volunteered that they had a sense of well-being though in one patient this sensation did not persist. The question of whether long term administration of MER-29 will result in untoward effects is at present unsettled. Frantz, Mobberley and Schroepfer[14] have shown that during MER-29 administration desmosterol accumulates in the tissues. The question has been raised whether this accumulation might result in either some toxic effect or the usual amount of atherosclerosis. Hollander, Chobanian and Wilkins,[11] however, have shown that MER-29 produces a significant decrease in total sterols, and Blohm[15] has demonstrated in animals that desmosterol is much more rapidly converted to bile acids than is cholesterol. These findings do not suggest significant accumulation of desmosterol.

Summary

Triparanol (MER-29) in single daily doses of 250 mg. was administered to six private patients with known hypercholesterolemia. Five of the six were instructed to avoid animal fats, while the sixth was already on a rigid low cholesterol diet. At 14 day intervals blood samples were drawn and analyzed for total cholesterol, phospholipids, triglycerides and total lipids. Five of the six showed decreases in the mean blood cholesterol level during the administration of MER-29 ranging from 5 to 62 per cent. One patient showed a mean increase in blood cholesterol of 1.5 per cent during MER-29 administration. No untoward effects were noted. It seems evident that triparanol (MER-29) will lower the blood cholesterol without rigid dietary restrictions and without appreciable side effects in some hypercholesterolemic patients.

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Volume XLVIII
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Corticoid Therapy of Infertility Associated with Anovulation and Elevated 17-Ketosteroids

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Early trails were blazed in the use of cortisone therapy for gonadal dysfunction when in 1951 the Wilkins group[1] described treatment of congenital adrenal hyperplasia with cortisone. Since that time several workers have pointed out the usefulness of cortisone and related steroids in what may be called borderline adrenogenital syndromes. In office fertility work one is rarely confronted with a severe adrenogenital syndrome, but is frequently responsible for the management of infertile patients with disturbances of gonadal function characterized by infertility, anovulation associated with menstrual irregularity or amenorrhea, grades of hirsutism and elevated 17-ketosteroids.

This paper reviews the syndrome and its therapy and confirms previous reports by Greenblatt, Barfield and Lampros,[2] Jones and Jones,[3] Jefferies, Weir, Weir and Prouty,[4] and others. The physiology of the malfunction present is best depicted by a graph which shows the mechanism of clearcut adrenal hyperplasia, of which the subject presented is truly only an intermediate or mild state (fig. 1). In this syndrome there is an isolated defect in the adrenal which limits the biosynthesis of the glucocorticoid hydrocortisone and occasionally the mineralocorticoids. Since the body homeostasis mechanism finds the plasma concentration of glucocorticoid abnormally low, the pituitary responds by secreting increased amounts of ACTH in an attempt to increase these plasma concentrations of glucocorticoids. The adrenal, however, responds to the increased ACTH in the only way it can, which is by hypertrophy and elaboration of a large amount of androgens, and some estrogens.

These androgens act on the pituitary and depress its output of FSH with the result that stimulation of the ovary is reduced, which carries the cycle on to the absence of ovarion estrogen, amenorrhea, atrophy of the uterus, et cetera. In variations and gradations of this mechanism, there can occur a high 17-ketosteroid level with typical androgenic masculinizing features. In other groups there may be some hirsutism and amenorrhea and yet a normal 17-ketosteroid, or there may be elevated 17-ketosteroid with little or no clinical androgenic effect. In some cases the adrenal may respond by increased adrenal estrogen which would produce the same effects so far as inhibiting the function of the ovary and yet causing neither androgenic changes nor elevated 17-ketosteroids.

Read before the District IV Meeting of the American College of Obstetrics and Gynecology, October 29-31, 1959, Miami Beach.

Mechanism of the Action of Corticoids

The mode and mechanism by which the adrenocortical hormones correct the defect just described are graphically pictured in figure 2. The concept is that cortisone or the related steroids produce their action by depressing the pituitary overproduction of ACTH, which in turn allows increased pituitary gonadotropic output, thus freeing the ovary from its former depressed state and allowing it to function in its normal manner. As the steroid therapy is continued, there is a decreased output of ACTH, thus a reduction in function of the zona reticularis of the adrenal with decreased androgen secretion, resumption of normal secretion of the pituitary gonadotropins, FSH, LH, and LTH, with resultant follicle stimulation, ovulation, corpus luteum formation, and cyclic elaboration of estrogen and progesterone with growth of the uterus, breast, vaginal epithelium, decreased hirsutism, increased pitch of the voice, biphasic or ovulatory temperature curve, and proliferative and secretory development of the endometrium.

Report of Cases

Case 1.—A 25 year old white nullipara consulted me in November 1956. The last normal menstrual period had been four months before, and there was a long history of menstrual irregularity and amenorrhea. Examination revealed a blood pressure of 140/80, mild obesity, slight hirsutism with chin stubble, hairy arms, male pubic hair

distribution, and a slightly enlarged clitoris. The cervix was clean; the uterus small and normal, the ovaries difficult to palpate, but possibly slightly enlarged bilaterally. My initial impression was borderline adrenogenital syndrome with the possibility of Stein-Leventhal syndrome. All routine examinations gave normal results including the protein-bound iodine determination, which was 5.4 gamma per hundred cubic centimeters. The urinary 17-ketosteroids, however, were 35.4 mg. per 24 hours, the normal being 8 to 13 mg. The typical basal body temperature was flat throughout, uniphasic, and never above 97.6 F. Administration of 5 mg. of prednisolone daily was begun on December 11, and continued through January and February 1957. On February 19 the 17-ketosteroids were down to a normal 3.3 mg. per 24 hours. There was a normal four day menstrual period beginning February 21. The three months' therapy ended in mid-March. About this time elevated basal body temperature indicated ovulation followed by menses March 30. Basal temperature indicated another ovulation about April 27. Pelvic examination on July 9 revealed a two month gestation. On Jan. 10, 1958 the patient delivered a normal 6 pound 1½ ounce male infant.

Case 2.—A 22 year old white nullipara was first seen in 1956 with a four year history of infertility. Her past menstrual history consisted of frequent episodes of six to eight months' amenorrhea. During the investigative phase she exhibited prolonged cycles of 32 to 36 days with a flat anovulatory uniphasic type of temperature curve. Examination revealed slight facial hirsutism, a tendency toward male pubic hair distribution, a rather large clitoris, a normal uterus, and slightly large ovaries. In October, 17-ketosteroid estimation was 36.5 mg. per 24 hours. The basal body temperature was anovulatory. Prednisolone, 5 mg. daily, was begun in mid-December. A normal menstrual period occurred on December 29, and on January 26 and February 26, 1957. The 17-ketosteroid determination, repeated on March 26, was 23.7 mg. per 24 hours. Therapy was continued, and when the patient was seen on April 27, with last menses February 26, the uterus was soft and enlarged to an eight week gestation. The antepartum course was normal, and she delivered a 6 pound 10 ounce male infant on November 5.

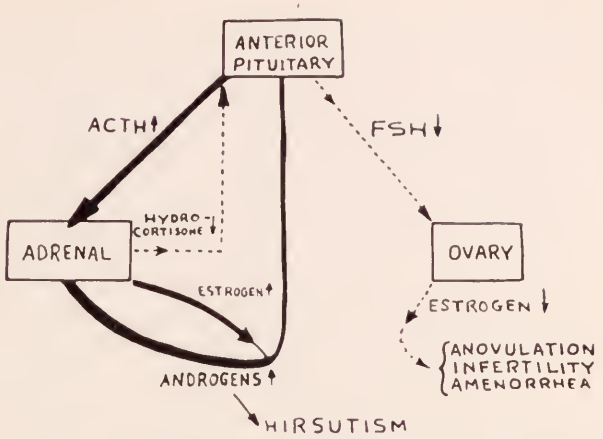


Fig. 1.—Hormonal interrelations in adrenogenital syndrome.

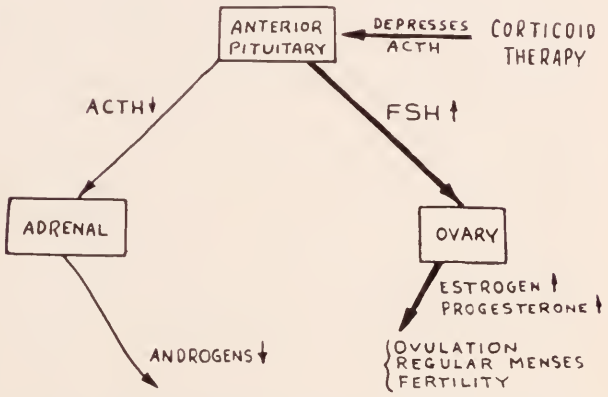


Fig. 2.—Mechanism of action of corticoid therapy in adrenogenital syndrome.

Summary

This paper outlines the probable primary mechanism which is present in women with anovulation and infertility accompanied by some hirsutism and elevated 17-ketosteroids. It appears that the defect is in the adrenal, which by producing inadequate levels of cortisone fails to regulate the pituitary secretion of ACTH. The adrenal responds to this stimulation by secreting large amounts of androgens, which in turn depress the pituitary FSH with resultant depressed ovarian function.

The probable mode of action of effective cortisone therapy lies in these steroids depressing pituitary output of ACTH which enables the adrenal to decrease secretion of androgens with resumption of the normal pattern of FSH output by the pituitary and resultant normal function and ovulation by the ovary. As a clinical illustration, two cases are summarized which exhibited anovulation, elements of amenorrhea, infertility, some masculinization and hirsutism, and elevated 17-ketosteroids. Treatment with corticoids resulted in decreased 17-ketosteroids and resumption of ovulation with ensuing pregnancy.

It appears that this group may represent an appreciable number of cases of ovarian dysfunction which are benefited by corticoid therapy.

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Hypovolemia Associated With Prolonged Shock Following Myocardial Infarction

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Myocardial infarction presenting with shock is not a rare occurrence;[1] however, prolonged hypotensive states requiring vasopressor therapy for weeks are distinctly unusual.[2] In 1956 Siglin[3] reported a case of survival in a patient who was supported for 14 days with levarterenol. Ordinarily, after relatively short periods of pressor therapy, the patient either regains his ability to maintain his blood pressure, or his condition deteriorates rapidly and he expires. The etiologic factors at play in these situations are poorly delineated, but among them are listed vasodepressor material release, absorption of endotoxins, myocardial failure, and adrenocortical insufficiency.[4] Hypovolemia has not been reported although its association with shock states has been thoroughly documented.[5]

The following case report is of interest not only for the long duration of shock in the patient with his subsequent recovery but also for the detection of hypovolemia as a feature of his post-myocardial infarction state, the correction of which was attended by dramatic improvement and cessation of need for pressor therapy.

Report of Case

A man, aged 81 years, was admitted to Mount Sinai Hospital of Greater Miami on Sept. 24, 1959 with the complaint of severe pain involving the precordium and left shoulder with radiation into the left arm, unrelieved by sublingual nitroglycerin. For some 15 years he had suffered angina with effort, quickly dissipated by nitroglycerin.

Physical examination revealed a blood pressure of 150/110 mm. Hg. and a pulse of 70, which was regular. The thorax was barrel-shaped, heart tones were poorly heard, and no precordial rub was noted.

The pain disappeared after analgesics were given, but two days later it recurred with such intensity as to require frequent administration of Demerol. At this time an electrocardiogram revealed deep, symmetrical T wave inversion in V_2 to V_5 compatible with an anterior wall infarction, the serum glutamic oxaloacetic transaminase went from 8 to 39 units, and the temperature rose over a 48 hour period to 102.2 F. (rectal). Over the following four days, the blood pressure slowly fell and on September 28 was 120/90 mm. Hg, at which time the patient manifested signs of clinical shock. Examination of stools for occult blood gave negative results. Aramine was administered with the systolic pressure being maintained at 130 to 160 mm. Hg; however, from that time until October 31, a period of 33 days, each of repeated attempts to withdraw pressor therapy was met with severe blood pressure depressions and the appearance of clinical shock. Therapy additionally included digitalization, anticoagulation, sedation and oxygen.

Electrolyte studies on two occasions were normal. The blood urea nitrogen ranged from 18 to 34 mg. per hundred cubic centimeters. Two 24 hour urine collections for 17-hydroxycorticoids contained 1.6 mg. (incomplete collection) and 4.3 mg. At this point hydrocortisone was administered intravenously for two days in doses of 200 mg. daily without beneficial results being observed.

From October 26 to 29 DOCA, 10 mg. a day, was given, and on October 30 blood volume determination indicated a plasma volume of 1,120 cc. per square meter of body surface (normal = 1,700± 290/M^2) and a blood volume of 1,930 cc. (normal = 2,900 ± 400/M^2), by the Evans blue (T-1824) method.

On October 30, 500 cc. of whole blood was given slowly and on November 1, for the first time since the patient's admission, the blood pressure was maintained at levels of 120 to 140 mm. Hg without benefit of pressor amines. A repeat volume study on November 12 showed plasma and blood volumes to be 1,490 cc./M^2 and 2,400 cc./M^2 respectively, values within the range of normal.

Conclusion

This patient's illness is reported as an instance of myocardial infarction attended by prolonged shock and accompanied by hypovolemia, the cautious correction of which was temporally associated with the disappearance of the shock state. No attempt is made to infer a causal relationship between the hypovolemia and the shock state; but rather it is our intent simply to note them as concomitant features of the illness.

We are indebted to Dr. Philip Samet of the Cardio-Pulmonary Section of the Department of Medicine and Dr. Arkadi M. Rywlin of the Department of Pathology of the Mount Sinai Hospital of Greater Miami for their helpful suggestions and review of this case report.

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Pseudomonas Corneal Ulcer in a Child

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One of the most alarming conditions involving an eye is a corneal ulcer resulting from Pseudomonas aeruginosa. It is a true medical emergency in ophthalmology.

Pseudomonas aeruginosa (Bacillus pyocyaneus or Pseudomonas pyocyanea) is an aerobic gram-negative bacillus which produces a round, smooth, moist, glistening colony having a fluorescent yellowish green color on culture.[1] It produces a tissue-destroying protease which may help to account for its corneal destructive powers.[2,3] The organism is found in water and sewage, occasionally on normal skin and in the intestinal tract of man.[1] Pseudomonas is comparatively resistant to some chemical antiseptics and can be a contaminant in boric acid, fluorescein, and normal saline solution.[4]

Infections from Pseudomonas aeruginosa seem to be more prevalent today because of the common use of penicillin which has interferred with the balance between cocci and bacilli permitting Pseudomonas to flourish.[5]

The organism is frequently introduced into the cornea as a consequence of a corneal injury such as an embedded foreign body, abrasion, or laceration. The bacterium takes about 24 to 48 hours to manifest itself clinically as a rapidly spreading white ulcer. A ringed area of necrosis with a semitransparent center is evident.[6] The conjunctiva is red and swollen, and a hypopyon may be present. If left untreated, the cornea will readily become disorganized.

Although colistin has been reported to be successful,[7] the presently favored and most available drug in therapy is polymyxin B, which must be started early. In controlled rabbit experiments, induced Pseudomonas corneal ulcers (1) did not form if treated at the time of inoculation, (2) were localized if treated in 24 hours, and (3) did not spread as rapidly if treated in 48 hours.[8] Treatment started after 48 hours is of little help, and the physician is fortunate just to save the globe once the organism is well established.[6] It is well, therefore, to take a scraping of the ulcer for a smear and a culture for sensitivity tests, and to institute immediate treatment based on clinical diagnosis. The smear may be of help at once, but the culture may require 24 to 48 hours. Polymyxin B may be administered both subconjunctivally in a dose of 50,000 units per day and topically by hourly drops of a solution containing 10,000 units[6] to 20,000 units per cubic centimeter.[9]

Report of Case

A two and one-half year old white girl was struck in the left eye by a toy metal saw at noon on Aug. 8, 1960. The mother placed some "mild eye drops" in the eye at 6 p.m. the following day and then put the child to bed. Later the little girl awoke with pain in the eye and was taken to the North Broward General Hospital for admission at 11 p.m., 35 hours after the accident.

Examination of the left eye revealed a 2 mm. oval white area centrally located on the cornea extending slightly inferiorly containing within its center a vertical thin laceration with closely approximated edges. The conjunctiva was red, but there was little discharge. Because of poor cooperation from the patient the examination was difficult at this time and at all other times.

The child was given tetanus toxoid 0.5 cc., and streptomycin 250 mg. with penicillin 200,000 units followed by one half this dose every six hours. She was given atropine 1 per cent topically once daily, and Neosporin ophthalmic solution (containing polymyxin B sulfate 5,000 units, gramicidin 0.025 mg., and neomycin 2.5 mg. per cubic centimeter) topically every hour alternated with sodium sulfacetamide ophthalmic solution 30 per cent every hour around the clock so that she received one or the other preparation every 30 minutes.

When the patient was seen again at 9 a.m. the next day, August 10, the white area appeared shockingly larger, and an immediate conjunctival culture was taken. At 2:20 p.m. the same day (about 50 hours after injury) under general anesthesia a scraping and culture of the ulcer were taken along with another conjunctival culture. The ulcer was cauterized with anesthetic ether on a cotton applicator followed by irrigation with normal saline solution, and 50,000 units of polymyxin B was injected subconjunctivally. Polymyxin was chosen because of the suggestive clinical appearance and course of a Pseudomonas corneal ulcer. No change was made in the medical regimen. From this point on, the ulcer became no worse.

The smear made from the scraping suggested a streptococcus, but on August 11, the report of every culture taken revealed Pseudomonas aeruginosa which, by the disk method, proved to be sensitive to kanamycin sulfate, neomycin, and methenamine mandelate.

The systemic penicillin and streptomycin therapy was maintained at the same daily dosage, but given in two divided doses; the topical atropine and sodium sulfacetamide were continued as before, but the Neosporin drops were increased to every 30 minutes. Two subsequent subconjunctival injections of 50,000 units of polymyxin B were given, one on August 13 and the other on August 16, under general anesthesia, making a total of three injections at three day intervals. The penicillin and streptomycin were discontinued on August 15. The patient was discharged on August 18, and given a regimen of topical Neosporin drops every 30 minutes, Neosporin ophthalmic ointment (containing polymyxin B 5,000 units, neomycin sulfate 5 mg., and zinc bacitracin 400 units per gram) at bedtime and once during the night, and atropine 1 per cent once a day.



Figure 1

On August 23, the Neosporin was reduced to the drops five times a day and the ointment at bedtime. The atropine was discontinued on August 25, and finally on September 6, four weeks after the onset, the Neosporin was discontinued. During this time the conjunctival and lid swelling which followed the injections diminished. The photograph (fig. 1) was taken on September 19, six weeks after the injury. The white scar measured about 2.5 mm. in diameter and extended one third of the way into the stroma, but failed to cause corneal thinning.

Comment

Although this is not a unique case of Pseudomonas corneal ulcer, it is worthy of note that on topical administration of Neosporin drops containing polymyxin B at frequent intervals the ulcer seemed to be growing worse and that after the first subconjunctival injection of polymyxin B, the disease seemed to be arrested. It also emphasizes the need for rather dramatic therapy even to the extent of administering general anesthesia repeatedly to facilitate subconjunctival injection of medication in children. One should not wait for the results of a culture before instituting treatment if the Pseudomonas organism is suggested by the clinical picture.

Summary

Some of the bacteriological and clinical characteristics of Pseudomonas aeruginosa infection of the cornea are discussed. It is suggested that immediate and aggressive treatment with polymyxin B topically and subconjunctivally is of utmost importance if one is to save vision. A Pseudomonas corneal ulcer in a two and one-half year old girl is described which required a general anesthesia on three occasions in order to employ subconjunctival injections of polymyxin. A comparatively favorable result was obtained.

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Making the Rounds

For a registrar reading during ward-rounds can be frustrating. Magazines may have to be read side-ways or upside down, and some of their contents deduced when pages are half-covered. Occasionally a badly placed newspaper can be moved while the chief is examining a patient, or position casually altered to a better vantage point. Unfortunately, it is the chief who decides when it is time to move on to the next patient. Sometimes an article in a very popular newspaper can be resumed at the next bed, but all too often the round ends with much that is of interest only half read, and with the nature of many half-covered illustrations still uncertain. It must be wonderful to be a consultant and read the patients' magazines and newspapers openly, turning them, uncovering them, and even holding up the round when necessary.—*The Lancet, June 10, 1961, page 1283*

Management of Secretory Otitis Media

Charles Pinkoson, M.D.
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Secretory otitis media has markedly increased during the past 10 years. Hoople[1] in 1950 stated that effusions of the middle ear represented about 3 or 4 per cent of the general otolaryngologists' practice. During the last week of March I saw 32 cases of secretary otitis media. Instead of 3 per cent, this was approximately 16 per cent of my patients. The cause of this increase has not been determined; it is believed to be associated with the treatment or inadequate treatment with antibiotic and chemotherapeutic agents.

Secretory otitis media may occur at any age; however, it is most often seen in children. In Armstrong's series of 1,016 cases, 78 per cent were in children eight years old or younger. This frequency is probably due to the greater lymphoid hypertrophy, more frequent upper respiratory infections, and poor immunity mechanisms which are more common in children.

Classification

There are many causes of this condition, and to manage secretory otitis media one must remember that there may be, and often is, more than one cause. The etiological classification by Sueh[2] is the one I prefer. He listed the causes under the following five headings:

1. Any condition causing swelling of the mucosa of the eustachian tube
   a. Upper respiratory infections, sinusitis, allergy, nasopharyngitis, and edema following swimming
2. Compression of the ostium or lumen of the eustachian tube
   a. Enlarged adenoids and lateral pharyngeal folds
   b. Malignant disease of the nasopharynx (I have seen three cases during the past two years in which a malignant lesion caused fluid in the middle ear)
   c. Enlarged lateral retropharyngeal nodes (resulting from malignant disease of the sinuses or nasopharynx, or leukemia)
   d. Malocclusion (eustachian tube compressed by the external pterygoid muscle)
3. Interference with normal tube function
   a. Aerotitis media
   b. Some cases of cleft palate
   c. Paralysis of tensor veli palatini muscle
   d. Trauma of eustachian tube orifice
4. Autonomic dysfunction and physical allergy
5. Aborted acute or subacute otitis media

Most physicians have divided secretory otitis media into two clinical types: serous and mucous. Senturia,[3] however, has divided effusions by means of microscopic examinations into four types: serous, purulent, mucopurulent, and mucoid. In his series there was a high percentage of positive cultures.

Diagnosis

The diagnosis of secretory otitis media is usually made from the history or from inspection of the eardrum; however, in doubtful cases a diagnostic tympanotomy may be necessary to support the diagnosis. A typical history is that a young child has an earache which is treated by an antibiotic. The patient recovers from the earache but does not seem to hear well. If the patient is older, there is often the complaint of a "blocked feeling," and if the tympanum is only partially filled with fluid, the patient may state that there seems to be a movement of the fluid when the head changes position. Usually the hearing is decreased in the affected ear or ears.

On inspection of the eardrum the diagnosis is easily made if one sees bubbles or a fluid line. It is much more difficult to make a diagnosis if the middle ear is completely filled with fluid. The drum then usually has an amber tint, and often the short process and the handle of the malleus have a chalky white appearance. If the drum is opaque or scarred, the findings are indefinite or absent. Auscultation can help in some cases; however, a diagnostic tympanotomy may be necessary to confirm the presence of fluid in the middle ear.

Read before the Florida Society of Ophthalmology and Otolaryngology, Jacksonville, April 10, 1960.

Treatment

When one treats secretory otitis media, it is necessary to treat the exciting cause as well as to restore ventilation of the middle ear. Also, it is necessary to remember that there often may be more than one etiological factor. If the eustachian tube is obstructed, a partial vacuum is created when the air in the middle ear is absorbed, and this causes a transudate of fluid. An infection in the middle ear usually causes an exudative type of fluid. There are many types of treatment for secretory otitis media, but all treatment should be directed at removal of the exciting cause of the fluid before or at the same time the abnormal ventilation of the middle ear is corrected. The treatment of secretory otitis media may be divided into three phases:

1. Local treatment of the eustachian tube
2. Systemic treatment of the eustachian tube
3. Drainage of the middle ear by myringotomy or by myringotomy and insertion of vinyl tube

In mild cases of secretory otitis media politzerization and mild vasoconstrictor drugs may be all that are required to cure the disease. If the secretory otitis media persists, an adenoidectomy should be performed if indicated, and it should be as complete as possible. While the patient is asleep is an excellent time to perform a myringotomy and aspirate the fluid in the middle ear. If the fluid is serous, it is removed with ease; however, if it is a thick mucoid material, it may stretch out like a rubber band and then retract into the middle ear. In cases of this type a wide anterior myringotomy and a posterior puncture aid in removing this "gluelike" fluid. In my experience this condition is the most likely to recur, and I am not sure but that in certain cases some of this thick material has been left in the middle ear in spite of persistent suction. In recurrent cases, I place a 1 mm. tube that is approximately 1 cm. long, with a 45 degree bevel, in the middle ear after removing the fluid. I have not tried putting the tube over a flame to cause the end to have a mushroom effect, but I understand this is effective in keeping the tubes in place. Another problem experienced is that some tubes have become clogged with dried exudate. I do not have the answer except to replace the tube.

In the chronic case it is necessary to be sure there is no tumor of the nasopharynx. If allergy treatment is indicated, it should be given. Thyroid hormone should be administered to the patient with hypothyroidism. In some instances, the corticosteroids are helpful. In Davison's series gamma globulin was advantageous in some cases by helping to build up resistance to infections.[4] Also, obesity was a contributing factor, and a low carbohydrate diet was recommended.

Summary

The etiological classification, diagnosis and treatment of secretory otitis media are discussed. In conclusion, I would like to stress that one should try to prevent loss of hearing and mastoiditis with its complications by performing myringotomy and aspiration of the middle ear when indicated. At the same time one should try to eliminate the exciting causes of this condition.

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The Effect of an Anabolic Agent Upon Intestinal Absorption in the Aged

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Significant gain in weight has been observed in normal persons and in those having organic disease following the oral administration of norethandrolone (Nilevar).[1-3] This compound has an anabolic effect equal to testosterone, but its androgenic effect is only one-sixteenth that of this hormone.[4] The present study was undertaken to determine the effect of Nilevar upon intestinal absorption in an aged population.

Methods

Fifteen male subjects 60 to 75 years of age were studied. The patients were not necessarily underweight, and some were slightly obese. All patients were initially hospitalized in the Durham Veterans Administration Hospital, and none had illnesses which would be expected to cause a change in weight over the period of study. Neither were they suspected of having either an absorptive or digestive defect.

The patients were divided into two groups by age. Group I consisted of nine patients, aged 60 to 69, and in Group II there were six patients, aged 70 to 75. The patients in Group I and II were given I^{131} labeled Triolein and I^{131} labeled Albumin by mouth, and blood radioactivity was determined at appropriate intervals. They were then given Nilevar, 10 mg. three times a day, for a period of four to six weeks, and the tests of absorption were repeated, using the same technique. Whenever possible weights were obtained before and after the study. Blood radioactivity curves were compared immediately before and after the administration of Nilevar.

Results

Mean blood levels of radioactivity expressed as per cent of administered dose before and after therapy with Nilevar are shown in the table. There was no significant difference in blood radioactivity after treatment with Triolein or Albumin between Groups I and II. Since the two age groups acted similarly, the remaining discussion will include both of these age ranges. Blood radioactivity after I^{131} Albumin and Triolein when averaged showed no significant difference before and after administration of Nilevar. It is noteworthy, however, that in all patients in whom a low blood radioactivity was noted initially, the blood values after administration of Nilevar returned to a normal level.

Symptomatic improvement was noted in most patients during this study, and a significant gain in weight was observed with an improved appetite and sense of well-being.

One patient became jaundiced and the findings on liver biopsy were consistent with cholestasis. Moderate bromsulphalein retention occurred in all patients on whom this test was made.

Discussion

Significant gain in weight has been observed following the administration of Nilevar in normal controls and in disease states. Patients with advanced mammillary carcinoma,[1] hyperthyroidism,[1] and postgastrectomy malnutrition[3] have gained weight while on this compound.

In the present study, conducted in an aged group, there was gain in weight ranging from three to 13 pounds with a mean of eight pounds. The mean (changes in) values of blood radioactivity following I^{131} Triolein and I^{131} Albumin in 11 patients were essentially unchanged; however, all patients who showed an initial low level of radioactivity had return of blood levels to normal after Nilevar therapy. The marked elevations in blood radioactivity in some of these aged patients might represent the high blood levels observed in an arteriosclerotic population.[8]

The gain in weight, following the use of Nilevar, appears to be due to an increase in appetite and a specific anabolic effect, rather than to an increase in absorption from the gastrointestinal

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This study was supported by grants from G. D. Searle & Company.
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Effect of Nilevar in the Aged

10 mg. t.i.d. for 4-6 weeks

				Blood Radioactivity*			
				Triolein		Albumin	
	Patient	Age	Weight Gain	Before	After	Before	After
Group I	R. S.	62	13	8.2	13.6	5.4	12.1
	E. C.	62		13.0	12.2	16.2	8.7
	R. B.	65	11	13.0	9.6		
	C. D.	65	9	17.2	15.6	12.0	7.4
	N. H.	64	3	9.6	10.2		
	G. A.	67		13.1	14.2		
	R. M.	60		5.9	15.8		
	T. S.	67		13.0	11.7		
	C. C.	63		10.0	11.1		
Group II	F. L.	70	12	6.0	9.0	14.8	14.2
	L. C.	70	5	13.3	12.3	12.6	12.7
	L. H.	70		12.0	12.9	12.4	14.0
	W.B.	75		18.4	16.6		
	W.M.	70		13.9	15.5	16.6	15.4
	J. D.	71		2.3	11.7		
Mean			8	11.2	12.8	13.0	12.1

*Blood radioactivity expressed in per cent of administered dose, average of four, five, and six hours after I^{131} Triolein and one, two, and three hours after I^{131} Albumin.

tract. It is true that the absorption of both Triolein and Albumin returned to normal in a few patients, but their gain in weight was not greater than that of patients whose absorption was unchanged. The significance of this observation is not apparent, but would be of interest, if verified. There was no evidence of excessive fluid retention in any of our patients. Androgenic effect was not observed. Bromsulphalein retention seems to be a frequent accompaniment of treatment with this compound, and cholestatic jaundice occurred in one patient. A dose of 30 mg. per day seems to be effective in promoting gain in weight without undue side effects.

Summary

Significant gain in weight occurred in a group of aged patients following the administration of Nilevar.

This gain in weight occurred without change in mean blood radioactivity after orally administered I^{131} Triolein and I^{131} Albumin.

Initial low blood radioactivity reverted to normal levels following the administration of Nilevar.

Nilevar in doses of 30 mg. per day may be employed relatively safely as an anabolic agent in aged patients.

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ABSTRACTS

A New Treatment of Radio-Ulnar Synostosis. By Louis P. Brady, M.D., and Eugene L. Jewett, M.D. South. M. J. 53:507-512 (April) 1960.

Any fracture occurring in the proximal ends of the radius and ulna, most particularly in the Monteggia type of fracture, in which sufficient disruption of soft parts has occurred to allow hemorrhage from one fracture site to pass into another presents the prerequisites for a potential radioulnar synostosis. This condition may occur with fractures of the proximal end of the radius only, without fracture of the ulna. Once the synostosis has occurred, the physician is faced with a problem of the first magnitude. The authors here offer a means of avoiding, or treating, if it has occurred, this difficult complication. Their approach to this problem is simply a method by which, with the use of an ordinary bone screw, the radius may be distracted the full distance from the ulna within the physiologic limits of the interosseous membrane which is still intact. They present two cases in which this method was used for the treatment of the pre-existing synostosis and a third case of Monteggia fracture in which a synostosis could reasonably have been expected and in which it was thought this complication was prevented by the prophylactic use of this distraction screw. In their opinion the method outlined offers a simple atraumatic technic of removing one of the major factors leading to a synostosis and should be useful both from the standpoint of prophylaxis and treatment.

Clinical Education — A Continuum. By Samuel P. Martin, M.D. J. A. M. A. 173:1307-1312 (July 23) 1960.

The clinical program here described aims not to cram the brain but rather to educate the person. It attempts to educate the scholar of medicine toward a specific end, the application of the scientific method to clinical practice. The scholar must be shown that the clinical practice and the acquisition of knowledge in this area come through the application of the scientific method to practice. This method consists of the continuous application and reapplication of four fundamental steps: stating the problem and studying it by means of observation, description, and classification; deducing the formulated theory and hypothesis; testing the theory or hypothesis; and revising and restating the problem. These steps have their counterpart in studying a clinical problem: a history, a physical examination, and basic laboratory tests are obtained; a tentative diagnosis is made; this diagnosis, or hypothesis, is tested by a clinical investigation; and the original impression and plans for treatment are revised. The investigator then reveals his findings to the patient and to his colleagues.

The author discusses clinical education in medicine from the standpoint of the theme, the environment, the participants, and the methodology and describes the program for clinical training at the University of Florida College of Medicine. He summarizes clinical education as an orderly continuum of increasing contact with patients, knowledge, responsibility, judgment, and skill, based on training in the application of the scientific method to the problem of the patient. The method is built around the solution of a problem, with two of the participants, the trainer and the trainee, working together as colleagues. The quality of the patient contact far outweighs the quantity.

Extrathoracic Aortic Shunt: An Experimental Technic. By Banning G. Lary, M.D., and John J. Farrell, M.D. South. M. J. 53:1162-1163 (Sept.) 1960.

To test an external aortic shunt secured in a vessel by a new form of anastomosis, and to test the feasibility of preparing a short term experiment in an animal wherein the entire blood supply of the descending thoracic aorta passed outside the body, experiments were performed on dogs. Semirigid vinyl plastic tubing was used, and the shunt described met the criteria of a satisfactory temporary aortic shunt, namely, (1) simplicity of design, (2) ease of introduction into and removal from the aorta, (3) sufficient lumen to permit adequate blood flow, and (4) enough security to prevent leakage and accidental dislodgment. In addition, this type of prosthesis functioned well outside the body for moderately long periods of time, exceeding by days the time required of temporary shunts for present operations. Experiments carried out on four animals showed that all the blood passing through the descending aorta can be diverted to the outside of the body in the dog by means of a plastic shunt for periods up to one week.

President's Page

Committees

For the past two years the Florida Medical Association has been working under its new Charter and By-Laws. For a better understanding I would suggest that all members study them very carefully. As you know, they may be found in the Florida Medical Directory.

The delegates to the Florida Medical Association are the final voice in the affairs of the Association. The delegates themselves are supposed to express the wishes of the component medical societies and thus in reality bring the affairs of the Medical Association down to the "grass root" level where they belong.

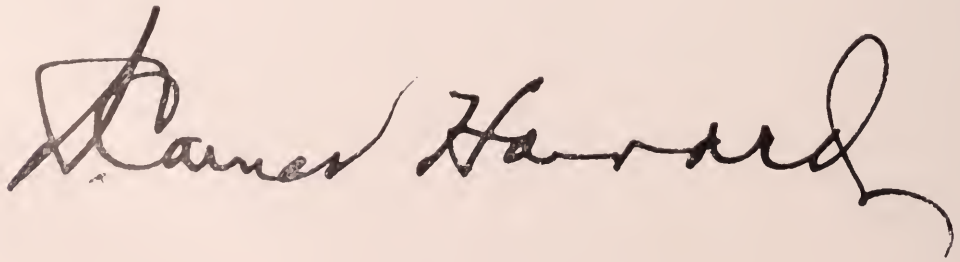
At the meeting of the House of Delegates, usually held only once a year at the time of the Association's Annual Meeting, various resolutions and recommendations are thrashed out in the reference committees and finally acted upon by the entire House of Delegates. The House of Delegates recommends to the Board of Governors what it wishes done. The Board of Governors, the Executive Committee and the officers of the Association as a rule then "carry the ball" until the next Annual Meeting unless something urgent comes up which requires a called meeting of the House of Delegates.

The Board of Governors and the Executive Committee cannot, by themselves, implement these directives and attend to the everyday business of the Association. The various Committees come into action here, and the committee members are the ones who really work during the year. The success of the Association depends upon these men and how well they do their job. Dr. Wachtel appointed good Committees, and because we are just getting "off the ground" with the new Charter and By-Laws, I have tried to keep up the continuity wherever possible with due regard to the ability, willingness to work and experience of the men concerned.

Because of vacations and for other reasons, at the time of this writing very few committee meetings have been held. Quite a number, however, have been scheduled for the next few weeks, and, of course, more will follow during the year. It is my sincere desire that all of these Committees carry their aims and objectives to conclusion in time for their reports to be printed in the next Handbook for Delegates.

I realize that meetings of Committees are not exactly fun and I also realize that it takes time and costs money to attend. Very frankly, I have assumed that each committee Chairman and each committee member realized these conditions and agreed to them when he accepted his appointment. Any member who is not willing to work for the Association in whatever capacity he has been appointed or elected to should resign and make room for somebody who will work. Each member of each Committee should make every effort to attend each meeting of his Committee. Every chain is only as strong as its weakest link. Let us make our Association unbreakable.

Any member of the Association, whether he is a committee member or not, should feel free at any time to express his views. He can best do so by communicating his thoughts directly to the very competent staff at Florida Medical Association headquarters.



EDITORIALS

Pit Viper Bites in the State of Florida

The bite of a Florida pit viper is uncommon, but a romantic and terrifying incident. Two small puncture wounds ¼ to 1 inch apart may eventuate in a wide scale of consequences ranging from no symptoms at all to a major catastrophe. The gravity of the situation may result even in the loss of an extremity, or death, and is dependent upon a single factor—the amount of venom injected. The primary purpose of this substance secreted and stored in a salivary gland, the venom gland, is to apprehend by paralysis its victim and by proteolytic digestion to nourish the snake. Without the evolutionary development of this mechanism the slow-traveling, heavy-bodied pit viper would have disappeared from the face of the earth. The minimum lethal dose of venom in man has been estimated in dried weight at 2 mg. per kilo and in dogs 4 mg. per kilo. The heaviest milking in a large rattlesnake is recorded at 864 mg. of venom dried weight, and the average adult rattlesnake at 300 mg. A bite may deliver half of these amounts or none at all.

Watt, Andrews, Parrish, Gennaro, Farrell, Evans, and a few others have been impressed with the importance of this injury in Florida. In a review of the juvenile amputees in this state in 1959, it was found that in 17 per cent of the surgical or traumatic group the amputation was due to snake bite. Recent polling of Florida physicians further disclosed 53 patients who had suffered severe extremity disability from the same cause. Thirty-six of these injuries had resulted in amputation and 17 in major loss of tissue with subsequent deformity and dysfunction.

As we all know, there has been little unanimity among us as to treatment. An analysis of bites in humans will never point the way to rational therapy. There are four pit vipers involved, and identification is not always possible. The amount of venom injected is extremely variable, from none to a lethal dose. Reaction to such an accident in the field is so inconsistent regarding therapy that no judgment can be passed on the value of tourniquet, incision and suction, immobilization, et cetera. It is obvious that the finalization of treatment must be based on principles achieved from the study of experimental bites in animals with venom of titred toxicity and in known amounts. These animals subjected to various therapeutic techniques, and compared with untreated groups, provide the only way we will ever achieve accuracy in the estimation of a suggested method of treatment. Much of this research has been done and reported in investigative literature, which rarely finds itself in the hands of the clinician. For instance, F. M. Allen in 1939 did exhaustive studies in animals which resulted in condemnation of the use of refrigeration in the treatment of snake bite. This was reported in the American Journal of Tropical Medicine. Yet, in 1950, only by assumption and not on sound investigative basis, this method of treatment was popularized and widely accepted by physicians. Only recently it was again condemned experimentally as added trauma to an already damaged extremity by Ya and Perry. It should be permanently excluded from our therapeutic armamentarium in the treatment of snake bite. Much has been clarified in favor of the value of immediate incision and suction by Gennaro, who tagged venom with radioctive iodine and could then measure a retrieve of 40 per cent of the amount injected in a subcutaneous experimental bite in dogs. This confirmed the qualitative work done originally by Dudley Jackson in 1928. Gennaro advocates the use of small incisions over each fang mark just through the skin. It has been well established that antivenin is the keystone of managment. Not one ampule but even 20 may be indicated, particularly in a child. Not only systemic collapse but the extent of local damage also may be diminished, or even controlled, by antivenin.

It is particularly important to assess the situation before embarking upon the administration of antivenin. A snake bite should not be the indication for treatment, but rather the characteristic clinical picture of venenation or venom poisoning. Many venomous snake bites do not result in the injection of sufficient venom to warrant any treat-

ment but the most conservative management; that is immobilization, a lightly applied tourniquet, and incision and suction for 30 to 60 minutes. Prognostic factors in predicting outcome are the number of fang marks and the length of time the snake holds on to his victim. When, however, one is confronted with a patient who has received a significant amount of venom, local pain and rapidly spreading edema appear. If systemic manifestations of fasciculation, numbness, tingling, paralysis, vomiting, convulsions, and shock soon follow, they demand the most radical form of treatment—namely the administration of antivenin. The pick-up by the circulation of intramuscularly injected antivenin is poor in a serious venenation where severe shock is present, and the intravenous route must be utilized.

Excision of the bite area and amputation, if done immediately, have been suggested to be of value in experimental bites in animals. There have been no clinical reports of its value in humans, but immediate surgical excision is worthy of consideration if proper conditions are at hand and if the bite is in an area amenable to such a procedure.

Prevention and education, in addition to therapy, must also be the goal in medical management of any problem. Identification placards of venomous snakes indigenous to each area, with summarization of treatment, should be placed on the wall of every hospital emergency room. Similar posters should adorn the walls of each public school library. The Florida State Board of Health has given assurance that it will pioneer the registration of venomous snake bites, by physicians. With these measures in practice, in five years a great pool of valuable information will be obtainable. It would prove that we, the physicians in Florida, are cognizant of our problem and are adopting more effective methods to combat it.

NEWTON J. MCCOLLOUGH, M.D.
ORLANDO

The Forty Hour Week—The Doctor's Dilemma

We physicians have devoted a great deal of thought in the last few years to what effect Government Medicine would have on medical care for the American people as they know it today. At the same time, we have given very little thought to the effects of the "40 hour week," which has changed the entire way of living of these people, thereby directly affecting the practice of medicine.

Admittedly, the 40 hour week is in many ways a fine thing; it provides families with the opportunity to spend more time together, to have more recreation, and to be healthier and happier. At the same time, we have taught the public that they should see their physician regularly, and that they should consult him when they detect the slightest symptom. More and more people are now following this advice, with the result of an ever increasing pressure on the physician's time. In addition to these increased demands upon his own time, the physician now finds his office hours, regarding employees, limited by this same 40 hour week. For example, in San Francisco today, physicians are unable to obtain employees who will work on Saturdays. This trend is rapidly spreading across the country, and I predict that the time will come when we will all have to close our offices on Saturday, because of this lack of employees.

Another consequence of the 40 hour week, by which we as physicians will be affected more and more in the coming years, is the marked reduction in the number of young people applying for entrance to our medical schools. Although there may be many factors involved, undoubtedly the long, unlimited working hours of a physician in private practice are a strong deterrent to many prospective doctors. I have found that new physicians entering the practice of medicine, particularly group practice, are exceedingly interested in how many hours per week they must work, how much vacation they have, how many nights they have off, et cetera, all of which is completely foreign to the older physician's thinking.

Most hospitals today, as a matter of course, expect their employees to be willing to work more than 40 hours a week, and it is a fact that the majority of these employees are underpaid

by today's standards. The time is rapidly approaching when, in order to attract competent personnel, the hospitals and physicians will be compelled to offer a 40 hour week, and commensurate salaries. Since one of the biggest factors in the health dollar is the cost of labor, this obviously means that hospitalization costs must double and probably triple. Dr. Howard Sprague, of Boston, has predicted that by 1970 the cost of a private room in a Boston hospital will be $65 per day. We, as physicians, shudder and figuratively hide our heads in shame at the mention of hospitalization costs rising, but this attitude is wrong on our part; while it is definitely our obligation to see that the patient's health dollar is not wasted, we are equally obligated to ensure the medical personnel's having the same working standards that the steel workers, the coal miners, and the automobile workers demand and have. This is only fair.

Whether we, as physicians, like it or not, our way of life and our practice have been affected by the 40 hour week, and we are now faced with the necessity of adjusting to these changes. We must learn to utilize better the limited time available to us, so that our skills and our training may be employed to greater advantage in behalf of the patient. We must work actively in recruiting more physicians and medical personnel—as an example, increased guidance at the high school level to encourage more outstanding students to enter training in medicine and its allied fields.

The changes which the 40 hour week have brought about in the practice of medicine will be an ever mounting factor in the next few years, and we must meet this challenge objectively, intelligently, and with vigor.

C. K. D.

Papers for Annual Meeting

The Committee on Scientific Work requests that members desiring to present papers at the Association's Annual Meeting May 9-13, 1962, submit an abstract prior to November 20. Those planning scientific exhibits should submit a short description to the Committee at P.O. Box 2411, Jacksonville 3.

Amistad

This Spanish word means friendship. The many thousands of physicians who practice their art in Central and South America and in the islands that lie between, should be our friends. We must know them better and respect them more; as friends and not just acquaintances. Most of these doctors speak Spanish (Portuguese in Brazil), and all of them are "different." This "difference" disappears when friendships are formed.

Valiant, though often erratic, efforts have been made by national and philanthropic medical groups to stimulate communication and cooperation between the doctors of this hemisphere. Scholarships have brought Latin American doctors to the United States and teams of truly devoted United States volunteers have gone into the rural portions of Central and South America to bring medical and spiritual gifts. But often, certainly not by design, friendship has been lacking. Impersonal, condescending attitudes have existed especially when "differences are great" and the "job to be done" is more important than the recipient of the job.

We physicians in Florida can bring friendship into these relationships. We should learn the rudiments of Spanish language and culture, a stimulating leisure activity. We should invite the children of Latin American physicians into our homes and send ours to theirs. Most of our colleagues live comfortably with conveniences, eating habits and morals close to our own. A month in the home of a "foreigner" can be an exciting experience to an adventurous teenager. We should invite individual physicians from Latin American cities and towns to our medical meetings, provide them with a place to stay and offer them an opportunity to participate in our meetings. (No federal financing needed here.) We might encourage preceptorship at the medical school level for temporary association with doctors in the large and small hospitals and universities. Again the emphasis on "live in" arrangements.

Friendships are not easily won and language and cultural barriers are still separating physicians of good will and intent. Here in Florida our nearness to the land to the South gives us unparalled opportunities to visit and be visited by our friends.

Courtlandt D. Berry, M. D.
Orlando

CLINICAL COMMENT

Under this heading, The Journal presents information gathered by Florida physicians attending the various medical meetings. The thoughts expressed are those reported by the author and are not intended as scientific references.

Obstetric-Pediatric Seminar

The Eleventh Annual Postgraduate Obstetric-Pediatric Seminar was held at the Colonial Inn in St. Petersburg Beach, Aug. 17-19, 1961. Dr. James M. Ingram, of Tampa, chairman of the Committee on Maternal Health of the Florida Medical Association, served as chairman of the program committee. The wide variety of subjects ranged from genetic counseling in pediatric practice, presented by Dr. William E. Laupus, Associate Professor of Pediatrics, Medical College of Georgia, to a "wide open" obstetric-pediatric panel discussion on medicolegal problems, a popular annual feature, led by Dr. Franklin J. Evans, of Coral Gables, and Edward B. Rood, a Tampa attorney.

Genetic disorders in man have emerged as the newest subject of importance in medicine, and children born with these conditions present difficult diagnostic problems for the clinician as well as socioeconomic problems for the parents. Physicians now are expected to explain to parents the risks for future children or future pregnancies. A knowledge of the previous maternal experience with Rh disease, a stillborn infant or a jaundiced infant will influence the counseling. A maternal antibody titer of 1 in 64 suggests increased danger to the infant and is the cut-off point. If the maternal antibody titer is 1 in 64 at the start of pregnancy, 37 per cent of the pregnancies will not reach 37 weeks. The genetic counseling also will depend upon a specific knowledge of the heterozygosity of the husband and the genotype of living children. Counseling takes two forms: giving information based on scientific fact, and guiding the parents in the direction that will enable them to make the best decision. In discussing Dr. Laupus' paper, Dr. Richard T. Smith, chairman of the Department of Pediatrics at the University of Florida College of Medicine, pointed out that it is the responsibility of the physician to temper the analysis of the problem with understanding, particularly with those parents who are not willing to accept the cold facts of reality.

In another presentation, Dr. F. Bayard Carter, of Duke University Medical Center, emphatically pointed out that psychiatry now has a major role in obstetrics and gynecology. Early discharge from the hospital prevents recognition of postpartum psychosis. The stress of pregnancy will bring to the surface weakness in psychological health, and verbal rejection of the pregnancy or the child is not necessarily pathological. The physician must be willing to listen, rather than talk, if he would uncover the possibility of an emotional stress reaction during pregnancy. He must help the patient to attain a mature state and to re-evaluate herself. Often group interviews allow her to verbalize much easier.

Two types of reactive functional psychoses occur in pregnant patients; 50 per cent are schizophrenic and 50 per cent depressive, evenly distributed among multiparous and primiparous patients. One in 400 who have come through a pregnancy will have a serious reaction. Sixty-five per cent of the psychotic reactions occur when the patient is at home during the lactation period, most often in women between the ages of 28 and 30. The rate is higher in patients subjected to cesarean section and in illegitimate pregnancies. The prognosis for patients having a schizophrenic reaction is four to five months' hospitalization for 20 per cent and up to two years or longer for the remaining 80 per cent. For the patient experiencing a depressive reaction the prognosis is better, with 75 per cent released from institutional care within one year.

Dr. Smith, in discussing psychiatric problems in pediatrics, emphasized that 90 per cent of these problems must be handled by general physicians because of the lack of psychiatrists and child guidance clinics. He cited reasons why the general physician is qualified to handle these cases: 1. He is well acquainted with the patient and his family and has their confidence. 2. He knows the family and family interrelationships. Some of the psychiatric problems the general physician probably can handle include those presented by the handicapped child, the mental defective, and the obese child. Problems that may require psychiatric aid include hysterical states, and encopresis.

In discussing ectopic pregnancy, Dr. Robert H. Barter, of George Washington University School of Medicine, stated that the mortality prior to the advent of the surgical approach was 70 per cent; with surgery the mortality is now

about 7 per cent. The diagnosis is difficult in many instances. The differential diagnosis includes pelvic inflammatory disease and threatened abortion, Müllerian duct cyst and uterine myoma. The danger is one of hemorrhage. In one study 74 per cent of the patients had more than 250 cc. of blood in the abdominal cavity. Exsanguinating hemorrhage occurs when there is a rupture at the cornual end of the fallopian tube. This is called the "coroner's end." Anemia, pain in the shoulder, abdominal pain, a history of venereal disease, previous exploration and the "bathroom sign" help make the diagnosis. Most important is the "ectopic awareness" of the physician. Culdocentesis is not a satisfactory procedure. Culdoscopy, colpotomy and exploratory laparotomy are more reliable and diagnostic. Clinical appraisal differentiates the surly, uncooperative patient with pelvic inflammatory disease from the worried, pale-tongued, impending doom patient with ectopic pregnancy and hemorrhage. Delay in diagnosis on the part of the patient or the physician frequently leads to a patient who is a poor surgical risk.

Confidential communications, contraceptive sterilization and the legality of abortions and prosecution of criminal abortionists were subjects of lively debate on the final day of the Seminar. Florida is one state that does not recognize privileged communications in medicolegal conflicts. In regard to abortions, many problems arise. Courts have asked physicians to perform abortions, but are unwilling to authorize them. Procured abortion is a better term than illegal abortion. Medical indications for abortion have declined rapidly; for example, heart disease and tuberculosis in pregnancy are no longer constant indications. Now the major problem is one of psychiatric reasons.

Accuracy and specificity of diagnosis are demanded today by the public. The basis of malpractice suits is dependent on the definition of ordinary practice in the community, and the specialist is expected to know more than the average physician. Laws are written in general terms and acquire significance only in specific instances.

Pediatricians have special problems, for the courts recognize that newborn infants require special care. The age of majority for consent purposes and the age of adolescent discretion were explained by Dr. Evans. A broad range of 15 to 20 years of school age is involved here. The statute of limitations also has special meaning for the pediatric patient. The date of onset varies with the date of injury and date of discovery. The age of majority may extend the statute of limitations in certain instances.

Nicholas G. Alexiou, M.D.
Gerald W. Powley, M.D.
Jacksonville

LETTERS

In this column, The Journal encourages open discussion of controversial subjects. Letters, to be published, should be in good taste and signed by the authors. The opinions expressed are those of the author and not necessarily of The Journal.

May 23, 1961

Kenneth Babcock, M.D., Chairman
Joint Commission on Accreditation of Hospitals

Dear Dr. Babcock:

The Chairman of our Board of Trustees (ours is a completely privately owned nonprofit hospital) accompanied us throughout the visit of the last surveyor. This chairman is "floored," a source of acute professional embarrassment to the staff.

We have a very active, conscientious, and intelligent group of trustees. Quite properly (at least in theory) they judge their own performance in maintaining a first rate hospital strictly in the light of the Joint Accreditation Commission's attitude. Perhaps then you can imagine the present dismay in the mind of the Trustee Chairman. He personally observed what the survey consisted of, conversed at length with the surveyor and now has found that we are *denied* full accreditation as the result of this "survey."

I am chairman of our Accreditation Committee; so I have made it a point to compare experiences with other hospitals in our state. The same sort of examples prevail: Intensive effort by everyone to rectify *all* of the deficiences indicated on last year's survey was given no apparent recognition by this year's inspector. Instead, he turned out a new list of criticisms, many of them false (he simply did not look at some of the things he called deficient). Most of the remainder of criticisms involved manifestly minor matters.

As in all hospitals, we have some staff members hard to convince of the desirability of accreditation. In an attempt to influence them toward better cooperation for the future, and to make it plain to the surveyor that our entire staff was intent on achieving accreditation, we

met at a luncheon on the day of the survey, and invited your surveyor to attend.

The results were dismal to say the least. The surveyor began with a little talk that was quite inapplicable to the circumstances, then asked for questions. Some members asked questions as to the reason for such and such a criticism in the past. The surveyor answered with no rationale whatever, only a polite, firm, brief statement that this was the decision of the Joint Commission. Now, I am sure that each policy of the Joint Commission has a logical reason behind it and any suitable comment about that reason would have been helpful. Instead, as each question was answered in the same fashion, it became obvious that the surveyor, in making criticisms, was doing it by rote, without any knowledge of the background to temper his judgment. In due time it became apparent that the surveyor thought we were needling him and began to show irritation. At this point we stopped.

In the next town, no such mistakes were made: The inspector was greeted by a glad hand artist, shown reams of paper indicating that most of the past year had been spent in preparing committee reports by various departments of the hospital. He was steered carefully to suitably selected parts of the hospital, given a nice lunch in private without being exposed to any of those old staff members and hurried away as soon as it could be done politely. He gave the hospital a three year accreditation.

This is wrong.

That hospital deserved accreditation, but he does not really know it. Accreditation is an excellent idea, and should be a wonderful thing; instead, it is missing the big boat it has built. The pendulum is bound to return, but please let us help it start.

To many of us, it seems time that the Joint Commission settle down to a limited scope of real effectiveness. We have written to the Joint Commission on a wide variety of subjects brought up by either a surveyor in years past or by a member who thought a certain small matter would be important in accreditation. An opinion was asked in each case, and *in every single instance an opinion was given.* This is totally unnecessary. There does not have to be an arbiter for every matter pertaining to all hospitals. If I wrote and asked what color to paint our nursery, I would be told the color, not that this was within the discretion of the local hospital officials.

It appears that much of this type of activity is based on a condition of being "over-lawyered." All sorts of things are being required in our hospital activities, many of them necessitating a substantial increase in cost of hospitalization, simply because in a remote town somewhere a lawyer succeeded in a damage suit against a staff member of a small hospital for a rather obscure reason. The risk of such a thing happening anywhere else, and particularly in our area, certainly is something that can be left up to lawyers in our area. And we should be permitted to accept that risk if we wish.

Some discretion needs to be developed toward making recommendations according to the size of the hospital. There are a number of important considerations which should be applied to any large hospital, especially a teaching one. And surely your "powers that be" are aware of the fact that some of these have no application whatever to a 50 bed hospital. The awareness is not shared by the lay people of a Board of Trustees, nor is it apparently shared by your surveyor. Can you think of anything sillier than the insistence that a 50 bed hospital with an active staff of eight general practioners should have formally organized, separate departments of Medicine, Obstetrics, Surgery, et cetera, with a chief of each department and proper monthly written reports from the chief of each section? This is the hat-changing gimmick reductio ad absurdum. There are at least six or eight other items in which no apparent discrimination is shown according to the size of the hospital, but this would grow too lengthy.

We are too busy for fooling around. We are glad to spend time that is productive, but hospital expense for patients is already too great to expend time and money on ineffectual brainstorms.

Recommendations:

1. Start making your "survey" a survey and not a sidewise glance. This will avoid foolish mistakes in your reports. Such mistakes may be relatively unimportant intrinsically, but the bitterness engendered in a staff falsely criticized nullifies much good. Accept only qualified surveyors.

2. Set up realistic standards applicable according to the size of the hospital surveyed. This does not necessitate changing any of your published policies. All you need do is require a little thoughtful judgment from the people who make the surveys. In the case of a requirement that is important in a teaching hospital only, the surveyor need only omit any reference to such a matter in his survey report of a small hospital.

3. Start recognizing your true importance, and stick to important things. Let somebody else run the question and answer department as to suggestions in various hospital administration problems. A pronouncement from your office has the weight of final authority, and should be reserved for things that deserve that much weight.

4. When less than full three year accreditation is awarded, your criticisms should be weighted to indicate which deficiencies are serious and important if the hospital expects to improve its status in the next year's survey.

5. De-emphasize paper. Necessary charts, formal procedures, all things involving *reasonably possible* legal action at some time or other, all should require careful record keeping. The listing, totalization, itemizing, summation, et cetera, that make up the paper superstructure of bureaucracy have become of overwhelming importance, regardless of whether the information contained on all of this paper will ever be of any use to anyone in the future. We might as well be socialized if this bureaucratic trend continues. The survey is using red tape methods to "cover the field," instead of actually personally inquiring and observing to find out if this is a good hospital. As things stand now, *it is not necessary to have a good hospital, only good paper work.*

We are gradually succeeding in persuading, browbeating, and encouraging the various members of our staff into accepting the good aspects of accreditation. We think it should be a wonderful thing. We only ask that your own activities be consistent with making it a wonderful thing.

W. E. Manry Jr., M.D.
Local Accreditation Chairman

OTHERS ARE SAYING

SURGICAL COMMENTS

Amos R. Koontz, M.D.

Disembowelment in the Field With Cure

The Amazing Feat of a Confederate Surgeon

The incident here related shows what can be done under the most primitive circumstances, with limited facilities, if the surgeon is conscientious, determined, and follows the elemental principles of good surgery.

In the early 1920's, in looking up the literature for a paper on "Rupture of the Diaphragm (Ann. Surg., 80:898,1924) in the Library of the Medical and Chirurgical Faculty of the State of Maryland, I came across Holmes' 3-volume *System of Surgery*. This was an English system, first published in 1870. The chapter on gunshot wounds was written by Dr. Hunter McGuire, of Richmond, Virginia, who at that time probably knew more about gunshot wounds than any other man in the world—for he had been the Medical Director of Stonewall Jackson's Second Corps of the Army of Northern Virginia. He had been responsible not only for all the wounded in that famous corps but also for all the wounded the Federals left on the battlefields after their numerous defeats by the corps' great commander.

In this chapter Dr. McGuire recounted a case of what he said was the most extensive wound of the abdominal parietes that he ever saw. A shell from a Federal gun had exploded very close to a Confederate officer and a fragment struck him 1½ inches below, and a little to the right of, the ensiform cartilage and passed downwards toward the right anterior superior spine of the ilium. The missile fractured 3 ribs on the right side, tore off the anterior superior spine and a part of the crest of the ilium, and laid open the abdominal cavity from the point where it struck to a point an inch below the anterior superior spine. The missile then continued on its course and inflicted a deep flesh wound in the upper and outer part of the right thigh. Dr. McGuire said that the officer had been treated by Drs. Amus and Walls of Virginia. The patient recovered and returned to duty in the field 8 months afterwards.

The family doctor of my family from 1865 to the time of his death about 1910 was Dr. Thomas B. Amiss, of Luray, Page County, Virginia. Dr. Amiss had been a Confederate surgeon, was a contemporary and close friend of my grandfather's, and I was named for him (although the spelling of the first name was changed). He and my grandfather, who had been a dispatch rider as a civilian (because of a crippled right hand from a hunting accident before the War he could not enlist), went to the Annual Meeting of Confederate Veterans together almost every year, Dr. Amiss always in his Confederate gray uniform.

It occurred to me that the Dr. "Amus" in Dr. McGuire's account might be my old family doctor who had delivered me and my 2 sisters. Ac-

cordingly, I wrote to Dr. Amiss's son, Mr. Frederick T. Amiss, and inquired if he could throw any light on this subject. He knew all about the case, and his father and his uncle had been the doctors who had taken care of the badly-wounded officer. Dr. Amiss had read an account of the case before the Association of Medical Officers of the Army and Navy of the Confederacy in Richmond in May 1908. I will let Dr. Amiss's own words give the details of how this case was handled:

> After the battle of Cedar Mountain in August, 1862, when our forces were falling back on Orange Court-house, my regiment, the 31 Georgia Infantry, formed the rear guard. We had not gone far before a courier came to the rear and asked for the surgeon, saying "that Dr. McGuire wanted him to look after a wounded man *near* the roadside." I asked the courier to guide me to the wounded man, and with my brother, Dr. William H. Amiss, surgeon of the 60th Georgia regiment, we arrived at the roadside and found the wounded man a few feet inside of a field.
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> I dismounted and going up to him, saw that his bowels were out, and called back to my brother, "the only thing to do to this man is to dig a hole and put him into it." The wounded man aroused and replied, "That is what Dr. McGuire told me, but if you d . . n doctors would do something for me, I would get well." I said, "My friend, do you know that your bowels are all out and covered with hen-grass, clay dust, and sand?" He again replied, "I had a hound dog run a mile with his guts out, and caught a fox; and I know I am as good as a dog, and can stand as much." I pulled his blanket from him and found that he was a Major. I said to my brother, "This man is full of all sorts of grit (meaning sand from the road and physical stamina as well) and we will do what we can for him."
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> I ordered my litter-bearers to carry him to a nearby farm house, Mr. James Garnett's, where we placed him on the dining table and proceeded to clean his wound, which was caused by a shell from the enemy's gun, which tore away the abdominal wall, crushed the bones of the hip, and narrowly missed the intestines. My brother washed out the abdominal cavity removing therefrom a handful of sand and vegetable matter. The point of the hip bone was broken and hanging down. This was cut off. The work was all carefully done, and the washing and sponging was done with salt solution. The sewing up of the wound, about 7 inches long, I did with ordinary Boss cotton and a calico needle. The wounded man was Major Snowden Andrews, of the Maryland Artillery, and later became Commander-in-Chief of the Khedive Army of Egypt.
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> This case is reported in Holmes' *System of Surgery*, Volume III, page 499, accrediting the operation to Doctors Amus and Wall, of Virginia, which should have been Dr. William H. Amiss and Dr. Thomas B. Amiss, his brother, as Major Andrews afterwards testified. The notoriety of this recovery was freely discussed by the medical fraternity of London just before the breaking out of the Franco-Prussian War, and it was suggested that the recovery was due to dust from the roadside which had completely settled over the wound, and careful surgery afterwards. This led to the practice of dust treatment for wounds in the Franco-Prussian War, and this in turn led to the use of antiseptic powders in wound treatment.

Dr. Amiss, who, with his brother, had graduated from the Medical School of the University of Pennsylvania shortly before the War, lived to a ripe old age and served a large practice faithfully and well all through the years until his death. I feel sure that I am correct in saying that no doctor in Page County ever enjoyed the confidence, trust, respect, and affection of the people of that county more than did Dr. Thomas B. Amiss. I shared all those feelings for him myself, and it is not without emotion that I pay this belated tribute to a man who was an ornament to our profession.

1014 St. Paul Street
Baltimore 2, Maryland

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AIDS TO PRACTICE

Questions and comments on appropriate economic and practice management problems are invited for publication in this column. Answers to your questions will be provided by a panel composed of various Florida members of the Medical-Dental-Hospital Bureaus of America.

Question: In June 1961 the House of Delegates of the American Medical Association adopted a resolution, voicing its stand on the proposed federal elder care legislation, in which it stated in part, "The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest, and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare." This has been referred to as the Magna Charta of American Medicine, and certainly is strong language. I believe in it and feel it is my obligation to make the present system of private enterprise medicine work in my day-by-day practice. "Ability to pay" is the nucleus of several of my practice management problems. What are your suggestions for the practical administration of the ability-to-pay element?

Answer: Necessarily this must be a straight-from-the-shoulder answer and somewhat more general than you may want. We feel American medicine is in its golden age of self determination, great professional productivity and high income

potential. A change is in process, and it could take easily the road of gradual encroachment and final full control by government planners and agencies. Strong words and good public relations programs by organized medicine will not suffice to stay this trend unless most practitioners reflect these good policies in daily dealings with their patients. Many physicians, we observe, fail to effect their good intentions with their patients either because they minimize the time and effort required for implementation of these intentions or by simple default to their aides. Whether a savory job or not, this problem must be met forthrightly now in each private office or the current stand re government medicine is infinitely weakened.

Ability to pay is a relative matter, and each physician would be wise, first, to organize his own thinking, then secondly, to relate this thinking to specific policies and specific routines in his office.

One patient who makes a wage of $130 a month readily pays the usual fee for his appendectomy, while another with monthly family income of $750 finds he has no money whatsoever available for his doctor. Obviously, this situation calls for some yardstick, a clearer concept, and perhaps appropriate means of communicating it to the public. For one thing, certainly you do not expect to deprive any patient of the necessities of life in order to pay your fee; these necessities include food, clothing, lodging, tools of a trade, and a highly variable list of other things commensurate with a person's employment or professional standing, and necessary to the retention of self respect.

Proper administration of the ability-to-pay element requires communication with and about the patient or responsible person. Appropriate and adequate economic history should be obtained on all new patients. The accompanying illustration shows a simple form by which this information is obtained with minimum staff time and effort; the patient completes the form while waiting for the doctor. This form may be produced by any printer. Subsequent conversation between patient and doctor or staff should bring out the probable cost of any major or extended care, the preferred manner of payment, and any undue hardship which would be caused by the fee named. Some physicians and nationally known clinics routinely verify this information with credit report sources, particularly when substantial care is involved. Your local Medical-Dental-Hospital Bureau can provide this information, or refer you to a reliable source.

Valid hardship and other circumstances related to the ability to pay often come to light only after care has been concluded. At all times,

PATIENT HISTORY INFORMATION Date....., 19.....
(PLEASE PRINT)

Patient.....Date of Birth.....
(Full Name of Patient, do not use Initials)

Name.....Phone.....
(Full Name of Husband, Father, or Responsible Party)

Widowed ☐ Divorced ☐
Married ☐ Single ☐ Given name of Husband or Wife.....
(If not shown above)

No of Children.....

Address..... | .....
(Street Number — City or Town) Zone

If Military.....
Serial # Rank Attached To

Employer..... | .....
(Employer of Patient or Husband, Wife, Etc.) Department

Employer's Address.....

Spouse Employed by.....

Referred by.....
(Full Name) (Address)

Nearest Relative and Address.....
(Relative Not Living at Same Address as Patient)

Insurance Company.....Policy No.....

(If this visit is payable by insurance, give details to secretary now)

the patient should be encouraged to discuss freely with the doctor or designated staff any matters which relate to this subject. The staff should be given specific instructions on the manner of handling all such responses. Consideration by the physician in each individual case usually is indicated, and he is wise to resolve each one by application of a fair, objectively determined policy rather than emotion or mood of the moment.

The final stage in the ability-to-pay administration is related to collection routines. Patients who do not respond to timely billing must be contacted by an appropriate precollection program, one purpose of which is to inform your patients of your policies regarding ability to pay and to encourage them to advise you of any pertinent facts. Finally, the unpaid accounts of patients who have the ability to pay should be referred in an appropriate manner to an established collection agency which will observe your policies on the ability to pay, an agency which is acquainted with the characteristics and necessities of medical practice and is geared to handle your accounts accordingly.

BLUE SHIELD

Vox Populi

Health insurance no longer has to be sold, but the competition is keen requiring that the type of program and the scope of benefits be presented in a convincing manner, backed by realistic products which meet the demand. Today, those who buy protection against the expenses of illness, be they the individual consumers or the executives of business and industry, are no longer impressed by the altruistic goal of the Blues, or swayed by their pioneering accomplishments of years ago. Pioneers are associated with the past, a part of revered heritage, who may well be out of tune with the times.

That this attitude is not merely sales propaganda of competitive carriers is borne out by the results of public opinion surveys sponsored by various groups, including Blue Plans and government agencies, and conducted by professional public opinion survey organizations. The picture they paint is none too bright, neither is it entirely black. The findings indicate that the future of the Blues, particularly Blue Shield, is bleak indeed unless a greater degree of flexibility is exhibited than those queried believe has been demonstrated in the past, and unless there are developed new and better programs in keeping with the demands of the times. They are reasonably well satisfied with the benefits received through Blue Cross, but Blue Shield allowances seem minimal in terms of the size of the doctor bill. Integrity and dependability are recognized as commendable characteristics of the Blues.

There is little indication that these surveys have penetrated extensively into Florida. Had they done so, it is highly probable that the findings might have taken on a brighter hue. Blue Shield of Florida is justifiably proud that it has not been resting on past accomplishments, bemoaning the inroads made by commercial carriers. Many of the initial steps the public is demanding have already been taken in Florida. Existing contracts have been expanded and improved, and extended benefits and master medical endorsements have been added. The new "K" Blue Shield contract is a long step toward providing benefits which more nearly meet the normal doctor bill. All these, however, although tangible evidence of the intent to catch up with the need and the demand of today's economy, are also indicative of how far we yet have to go to reach the comfortable feeling of being out in front. People strongly indicate that they want broader coverage—diagnostic coverage and house calls—as well as greater protection against the big bills.

Changing attitudes, made apparent by comparison with previous surveys, merit careful consideration. Whereas, previously the public was concerned about the possibility of socialized medicine, it is no longer a disturbing factor, even to the extent of qualified endorsement. People are in favor of the Kennedy care-for-the-aged program. Although national, state, and local medical societies have expended substantial money and effort into public relations activities, the doctor image has steadily deteriorated, extending even to the individual's personal physician. There is a feeling that doctors should be the last persons to direct Blue Shield. This reaction is quite different from that previously evidenced.

The medical profession may question the judgment of those participating in the survey, but it would be injudicious to ignore the implications.

NEWS-PERSONALS

Dr. James H. Ferguson of Miami, Professor and Chairman of the Department of Obstetrics-Gynecology at the University of Miami School of Medicine, participated in the World Congress of Gynecology and Obstetrics held September 3-6 in Vienna, Austria. Dr. Ferguson served as honorary chairman of one of the sessions and also presented a paper entitled "Correlation of Cytologic and Histopathologic Data in Carcinoma of the Cervix."

Dr. Ivan Isaacs of Jacksonville presented testimony before the House Ways and Means Committee in Washington early in August in opposition to HR 4222, the King-Anderson Bill. He represented the Florida Radiological Society of which he is vice president.

Dr. James G. Thomson, chairman of the Department of Pathology at the University of Cape Town, Union of South Africa, is serving for one semester as exchange professor of pathology at the University of Miami School of Medicine. Dr. W.A.D. Anderson of Miami, who is chairman of the Department of Pathology at the University of Miami School of Medicine, is taking Dr. Thomson's place in Cape Town.

Dr. Wilbur C. Sumner of Jacksonville has returned from a tour of Spain, France. Switzerland and Italy. In Spain, he was guest speaker at the University of Madrid College of Medicine, and at the University of Milan School of Medicine in Italy, he discussed cancer research.

Dr. Jere W. Annis of Lakeland has been attending conferences in Washington, D. C., with representatives of the Social Security Administration.

The University of Florida College of Medicine has announced receipt of two grants, one of $38,000 for a special study on the surgical treatment of breast cancer in women, and the other of nearly $200,000 to support training programs in neurology. Dr. Edward R. Woodward, chairman of the Department of Surgery, and Dr. Lester R. Dragstedt, Research Professor of Surgery, will conduct the study on surgical treatment of breast cancer, and Dr. Richard P. Schmidt, Professor of Medicine, will direct the training programs in neurology.

Dr. Lauren M. Sompayrac of Jacksonville has returned from a tour of England and the continent of Europe. While in Liverpool, he attended the meeting of the British Association of Dermatology and participated in discussion of cases presented at the Royal Infirmary at the University of Liverpool School of Medicine. He is an honorary life member of the Association. He visited various clinics in Rome, Naples and in Paris.

Dr. Harold O. Hallstrand of Miami gave a presentation on "Peptic Esophagitis" and also served as a member of the panel on "Cancer of the Colon" at the recent Twenty-Sixth Annual Congress of the North American Federation of the International College of Surgeons. Dr. Hallstrand is a Regent for the College in the state of Florida and is Vice President of the United States Section.

The University of Miami School of Medicine has announced that Dr. John A. D. Cooper, Associate Dean of Northwestern University Medical School, will be unable to accept the position as Dean of the School of Medicine because of illness. Dr. Robert B. Lawson, Professor of Pediatrics and chairman of the Department of Pediatrics, will continue as interim dean.

Dr. George F. Schmitt of Miami, secretary-treasurer of the Florida Diabetes Association, has announced that a combined arthritis and diabetes seminar will be held at the Balmoral Hotel, Miami Beach, October 18-20. The seminar is being presented by the Florida Chapter of the Arthritis and Rheumatism Foundation and the Florida Diabetes Association in cooperation with the Florida State Board of Health and the medical schools at the University of Florida and the University of Miami.

The Department of Surgery at Emory University School of Medicine is presenting a post-graduate course in Cancer Chemotherapy October 19-20 at Emory University Hospital. Information may be obtained from Dr. J. D. Martin Jr., Professor and Chairman, Department of Surgery, Box 459, Emory University, Atlanta 22, Ga.

Dr. Dewitt C. Daughtry of Miami, president of the Southern Chapter of the American College of Chest Physicians, has announced that the Chapter will meet November 3-4 at Dallas, Texas.

Dr. Paul S. Jarrett of Miami has been elected president of the Greater Miami Society of Psychiatry and Neurology. Serving with Dr. Jarrett will be Dr. Irwin S. Jacobs of Miami as vice president, and Dr. Stanley I. Holzberg of Coral Gables as secretary-treasurer.

Dr. Mozart A. Lischkoff of Pensacola has been voted an honorary life member of the American Medical Society of Vienna, Austria.

A Seminar in Clinical Medicine and Surgery, sponsored by the Duval County Medical Society, has been scheduled for November 12 in the Robert Meyer Hotel at Jacksonville. Dr. Matthew E. Morrow of Jacksonville is program chairman. Six hours of Category I credit may be gained by attendance.

The University of Miami School of Medicine, Section of Thoracic and Cardiovascular Surgery, has announced the following Post Graduate Cardiac Surgical Colloquia for October and November: October 14, "Surgical Treatment of Thoracic Aneurysms," Dr. Myron W. Wheat Jr., Assistant Professor of Surgery, University of Florida College of Medicine; October 28, "Survey of Surgery for Valvular Heart Disease," Dr. Charles P. Bailey, Professor and Chairman, Department of Surgery, New York Medical College; November 11, "Homologous Blood Syndrome During Clinical Cardiopulmonary Bypass," Dr. Howard L. Gadboys, Clinical Assistant Professor of Surgery, University of Miami School of Medicine. The conferences are scheduled for the Pathology Conference Room of Jackson Memorial Hospital.

MEETINGS

October

Florida Academy of General Practice, Oct. 6-8, Hotel Diplomat, Hollywood

Florida Diabetes Association, Oct. 18-20, Balmoral Hotel, Miami Beach

Florida Psychiatric Society, Oct. 21-22, Grand Bahama Hotel, West End, Grand Bahama Island

Florida Orthopedic Society, Oct. 21-22, Boca Raton Club, Boca Raton

Seminar in Orthopedic Surgery, Oct. 26-28, College of Medicine, University of Florida, Gainesville

November

2nd Postgraduate Medical Seminar Cruise, Nov. 2-12, S. S. Hanseatic, College of Medicine, University of Florida, Gainesville

Seminar in Clinical Medicine and Surgery, Nov. 12, Hotel Robert Meyer, Jacksonville

Florida Urological Society, Nov. 3-5, The Inn, Ponte Vedra, Fla.

Florida Pediatric Society, Nov. 9-12, Cherry Plaza Hotel, Orlando

December

Florida Obstetric and Gynecologic Society, Dec. 1-3, Gault Ocean Mile Hotel, Fort Lauderdale

Florida State Surgical Division, International College of Surgeons, Dec. 1-2, College of Medicine, University of Florida, Gainesville

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Dame, George M., Lake City
Davis, Herbert H., Miami Shores
Ferguson, Thomas B., Tampa
Lee, Robert E., Tampa
Lowery, Willa D., Pensacola
Sachs, Julian S., Indialantic
Spoto, Nelson J., Tampa

Associate

Amdur, Joseph, Coral Gables
Avellone, Theodore M., Hollywood
Berman, Donald A., Hollywood
Ellis, Charles T., Hialeah
Feltman, Robert F., Miami
Fening, Walter E., Lantana
Ferrara, Louis V., Sarasota
Foust, Betty J., Fort Lauderdale
Henry, John B., Gainesville
Hodge, Maurice, Miami
Jackson, Louise O., Pompano Beach
Jenkins, Wilburn R., Orlando
Kramer, H. Coleman, Miami Beach
Levine, Robert L., Miami Beach
Lindberg, Dale K., West Hollywood
Lowe, Charles E., Hollywood
Messenger, George P. Jr., Fort Lauderdale
Meyer, George J., Fort Lauderdale
Myers, Milton B., Hollywood
Nevis, Arnold H., Gainesville
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Parker, Lemoine B., Orlando
Pauk, Z. D., Miami
Potash, Irwin M., Miami
Schiebler, Gerald L., Gainesville
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*Gamble, C. J.: Am. Pract. & Digest Treat. *11*:852 (Oct.) 1960. See also Berberian, D. A., and Slighter, R. G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Olson, H. J.; Wolf, L.; Behne, D.; Ungerleider, J., and Tyler, E. T.: California Med. *94*:292 (May) 1961; Kaufman, S.A.: Obst. & Gynec. *15*:401 (Mar.) 1960; Warner, M.P.:J.Am. M. Women's A. *14*:412 (May) 1959.

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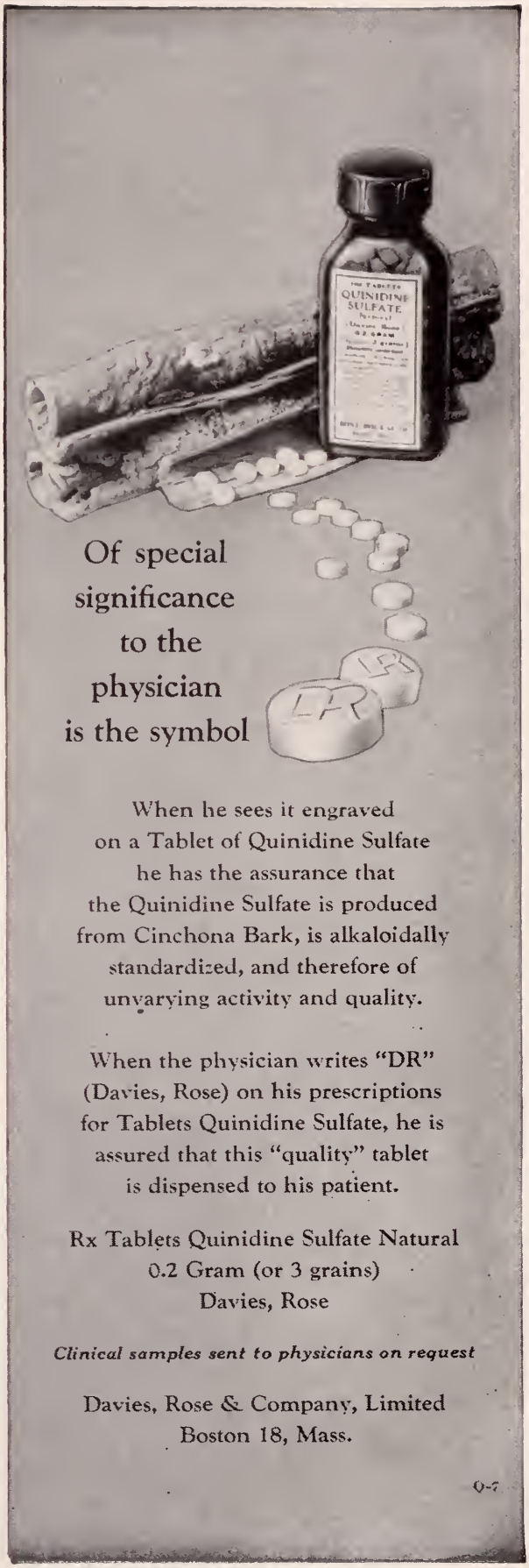
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BOOK REVIEWS

Synopsis of Pathology. By W. A. D. Anderson, M.A., M.D., F.A.C.P., F.C.A.P. Ed. 5. Pp. 876. Illus. 414. Price, $9.25. St. Louis, The C. V. Mosby Company, 1960.

The author needs no introduction as his contributions are worldwide and his texts are familiar to all American medical students. He deserves the admiration of the medical profession for his labors in offering this synopsis. Though it may not appear particularly spectacular to some, it certainly is intellectually satisfying to most. Pathology shares the problems of the entire medical field, and so with every discovery in medicine the pathologist is compelled to familiarize himself with each new development and pursue the complications that arise from it. It was Osler who remarked that the best training for the clinician was to go every day to the dead house. Though this may have been necessary 80 years ago, today our libraries defray the time and inconvenience of such an obligation. The author has contributed to this modern luxury by organizing the complex material and comprehensively presenting it in this concise but thorough outline. He has not intended this volume to compete with large texts copiously overflowing with abundant elementary details and references, but instead has designed it as a condensation for students and house officers. Its usefulness may be extended to clinicians in practice as well.

The last edition having been published three years ago, this fifth volume necessitated many changes due to recent developments in regard to infective processes, neoplasms, vascular diseases, endocrine disturbances, allergic manifestations and newly recognized syndromes. The introduction of radioactive isotopes as well as the recognition of sex chromatin and new cellular diseases required additional informative space. The text is patterned into 25 sequential chapters and adequately illustrated with gross specimens, photomicrographs, drawings and tables. The printing type is visually large and the composition is easy to read. The more common and important diseases are described in greater length, which is as it should be, and the book has a wealth of material. The cover and pages are durably bound and will tolerate much digital use. It is without hesitation that this fine little book is recommended both for its contents and price.

Clifford C. Snyder, M.D.

Medical Research and the Death Penalty. By Jack Kevorkian, M.D. Pp. 75. Price, $2.50. New York, Vantage Press, 1960.

Presented in dialogue form within this book are arguments for and against a practice which is said to have been carried out 2,000 years ago at the famous school of medicine in Alexandria, Egypt, and then to have lain dormant until revived by Dr. Kevorkian, a pathologist. The author proposes that "men condemned to death by due process of civil law during peace time be allowed to submit, by their own free choice, to medical experimentation under surgical anesthesia, to be started at the set minute of execution and from which they will never awake." He argues that animal experimentation is not always transferable to human beings, that it is senseless to "smash" the bodies of those whom the law says must die when by proper technique information could be gained that would help the living while still carrying out the dictate of the court, that if carried out under the rigidly controlled conditions he sets forth it would be considerably less cruel than the gas chamber or hangman's noose and finally that interviews with condemned men indicate it would be acceptable to some and even give them a feeling of partial atonement for their misdeeds. This book is thought-provoking and sets forth what this reviewer believes is an idea worthy of serious thought and action.

William M. Straight, M.D.

(Continued on page 376)

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This distinction appears to be no longer necessary since glucosamine, a highly acceptable excipient for oral antibiotics, now is being incorporated uniformly in all such forms, thereby simplifying nomenclature and your prescription writing.

Accordingly, and effective immediately, forms incorporating glucosamine will be offered simply as Terramycin without the "Cosa" prefix.

To make clear just which forms are affected, please refer to the brief tabulation (below) of Terramycin dosage forms both *before* and *after* this change. We are also requesting our representative to call on you at an early date to answer any questions that may arise.

We feel certain that this action, prompted by your comments and those of many other physicians, will simplify your writing of prescriptions for Terramycin products.

We welcome your comments on this action and on any other phase of our operations, since it is our objective to render every service as efficiently as possible to our friends in the medical profession.

Sincerely,
PFIZER LABORATORIES

The following table indicates the former name and the current name of Terramycin systemic preparations:

FORMERLY NAMED	NOW NAMED
Cosa-Terramycin® Capsules	**Terramycin**® Capsules*
Cosa-Terrabon® Oral Suspension	**Terramycin** Syrup
Cosa-Terrabon Pediatric Drops	**Terramycin** Pediatric Drops

and simpler names for these Terramycin-containing formulations:

Cosa-Terrastatin® Capsules	**Terrastatin**® Capsules
Cosa-Terrastatin for Oral Suspension	**Terrastatin** for Oral Suspension
Cosa-Terracydin® Capsules	**Terracydin**® Capsules

. . . and these names remain unchanged:

Terramycin Intramuscular Solution
Terramycin Intravenous

**Terramycin Capsules* without glucosamine *are no longer available.*

The clinical versatility of Terramycin is enhanced by its specialized dosage forms adapted to individual needs—*another reason for the trend to Terramycin.*

(Continued from page 374)

Rypins' Medical Licensure Examinations. *Topical Summaries and Questions.* By Walter L. Bierring, M.D., M.A.C.P., M.R.C.P., Edin. (Hon.), with the Collaboration of a Review Panel. Ed. 9. Pp. 805. Price, $11.00. Philadelphia, J. B. Lippincott Company, 1960.

This compact, concise and orderly presentation of the various fields of medicine as an aid in reviewing for licensure and other examinations, now in its ninth edition, has been thoroughly revised and brought up to date. The basic features which have made this a popular and widely used standard review text—full and authoritative summaries of each subject and carefully selected questions covering essential facts contained in these summaries—have been retained. The initial article on Medical Qualifying Examinations has been revised in accord with the results of a series of Examination Institutes conducted by the Federation of State Medical Boards of the United States during the past three years in the testing of fitness to practice. Part I—Basic Medical Sciences covers Anatomy, Physiology, Biochemistry, Microbiology, Pathology and Pharmacology; Part II—Clinical Sciences covers Surgery, Internal Medicine, Obstetrics and Gynecology, Preventive Medicine and Public Health, and A Synopsis of the Scope, Goal and Content of Psychiatry. The individual subjects have been covered in such a way that the material serves as appropriate study and preparation for all types of tests—whether oral or written, essay or objective.

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Aids to Medicine. By. J. H. Bruce, M.D., M.R.C.P. Ed. 7. Pp. 391. Price $3.50. London, Baillière, Tindall and Cox, 1960. Baltimore, The Williams & Wilkins Co., exclusive U. S. agents.

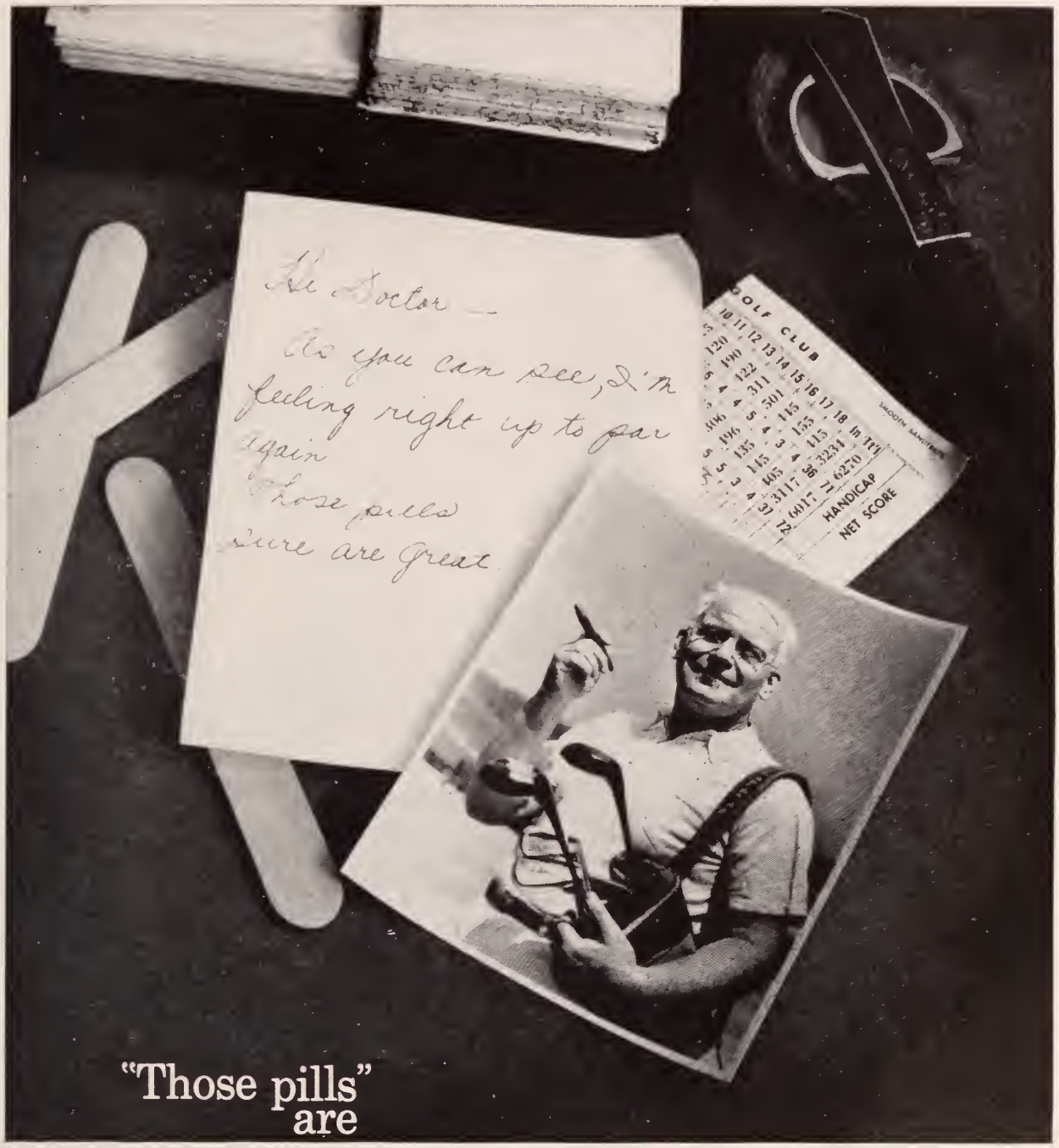
This pocket size book is designed to present to the student the essentials of general medicine in a concise and readable form. This seventh edition has been revised to include developments in therapy and the newer and more ambitious surgical procedures, modifications to the author's views on the use of steroids in a number of conditions such as asthma, rheumatic fever and the nephrotic syndrome, and additions and changes in the treatment of malaria, tuberculosis, and some of the blood diseases such as polycythemia, and mention of carcinoid tumors and Coun's syndrome.

Ciba Foundation Colloquia on Endocrinology. *Volume 13.* Human Pituitary Hormones. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc. Pp. 336. Illus. 86. Price, $9.50. Boston, Little, Brown and Company, 1960.

With the recent synthesis by Hofmann and his group at Pittsburgh of a fully active corticotropin 23 aminoacids in length, only a week after Li, at the University of California had independently synthesized a 20 per cent active ACTH with 19 aminoacids in length, a wonderfully exciting new field of human achievement reaches matur-

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This volume of Ciba's excellent series presents verbatim the papers presented in Buenos Aires at a colloquium honoring Prof. Bernardo A. Houssay just before the Twenty-First International Congress of Physiological Sciences. It was the work of Houssay and his disciples in the mid twenties that opened the door to the vast field of study of the pituitary hormones. The colloquium reviews and brings up to date all knowledge on this important subject with the papers and discussion of 32 international authorities including nine American scientists: E. Anderson, G. Corner, C. Li, O. Pearson, M. Raben, C. Read, J. Russell, M. Sonnenberg and A. Wilhelmi. Like all previous volumes of the Colloquia series, this is indispensable in any medical library and essential to every man working in the field, whether he is a research physiologist or a practicing endocrinologist.

Carlos P. Lamar, M.D.

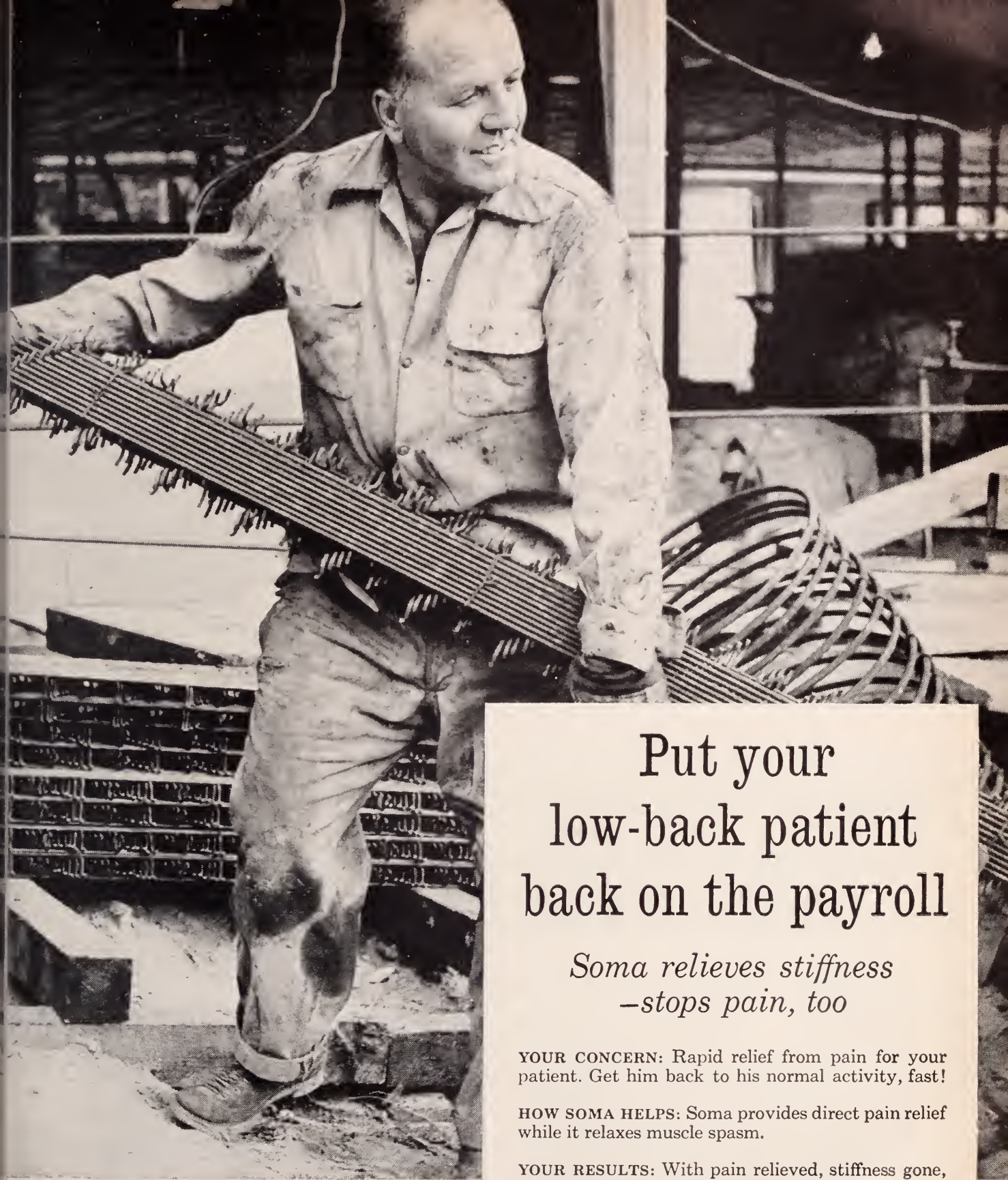
Sea Within. The Story of Our Body Fluid. By William D. Snively, Jr., M.D. Pp. 150. Price, $3.95. Philadelphia, J. B. Lippincott Company, 1960.

Anyone who has ever wondered about the miracle of human life will find this book of interest for in it the very essence of that life is described and illustrated. A simply stated yet scientifically accurate presentation of the subject of fluid and electrolyte balance, it incorporates much recently acquired knowledge concerning the body fluid, such as that in connection with the hormone, aldosterone, and that on the role of potassium in body physiology. The book is intended primarily for the great number of laymen who are intrigued by the scientific aspects of human life, but it should also be of interest to physicians, nurses, technicians, dietitians, and students as background reading for technical treatises on body fluid, the ancestor of which was the primeval sea. It provides an unusual synthesis of science and the humanities in its discussion of an all-important subject.

Ciba Foundation Symposium on Cellular Aspects of Immunity. Edited by G. E. W. Wolstenholme. O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 495. Illus. 117. Price, $10.50. Boston, Little, Brown and Company, 1960.

The particular place was in an old monastery located in the tranquil wooded province some 20 odd miles north of Paris and is known as the cradle of French civilization. It afforded 32 invited outstanding authorities an atmosphere of relaxation and inspiration for thought on the subject of immunology. The co-editors have done remarkably well in collecting the discussions so that others may benefit. The symposium centers around the immunologically competent cell with its permeability and phagocytic properties rather than the antibody per se. Studies of the precise mechanism of how the living cell engulfed protein were made possible by fluorescently labeling the proteins. The role of the lymphocyte for a long time has been thought to synthesize antibodies, but this concept is being tested now and the number of authors who favor the plasmocytic theory is increasing. In order to prove such theories, the ultrastructure of the cell must be known and recognized. The electron microscope illustrates that the cytoplasmic ultrastructure of a lymphocyte is totally different from that of the plasma cell. Some authors think the lymphocyte may be the carrier of antibodies produced by a plasma cell. They have shown that the plasma cell resembles a specialized factory that produces proteins and its ultrastructure is exactly that of a gland. The contributors to this symposium are under the impression that soon the answer will be known as to the phenomenon of tolerance and immunity. This should be most interesting to the internist, allergist, immunologist and those dealing with the transplantation of tissues.

Clifford C. Snyder, M.D.



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Office Diagnosis. By Paul Williamson, M.D. Pp. 470. Illus. 350. Price, $12.50. Philadelphia, W. B. Saunders Company, 1960.

This is another "From the Symptom to the Disease" type of book. What makes it most valuable is the fact that the author was a professional writer before becoming a physician and he knows how to write well and makes the reading of each chapter an entertaining and actually delightful experience.

In addition to his premedical experience as a professional writer and radio actor, which seems to have sharpened an undoubtedly congenital high sense of humor, the author practiced for several years "in the most isolated area of Colorado," where he designed and built his own little hospital and, as he puts it, "had to learn medicine and surgery for (he) was the only doctor available." Now retired to full time writing and research in Jamaica following a coronary attack, Dr. Williamson is also the author of "Practice," a letter sent every few weeks from a small pharmaceutical laboratory in Texas. The letters are a vehicle for advertising some preparations, but in themselves contain many smart observations and humor galore. They are mailed to physicians throughout the country like so many others are nowadays.

The book is large, with large type for easy reading, and the many line illustrations are well done by the author's artist-wife. After an interesting chapter on "The Art of Diagnosis" follow chapters listing and discussing symptoms under 12 general groups. Many possible diseases are studied under each diagnostic title. The language of the book is easy, and the author takes the reader step by step in reasoning the significance of each particular finding. He stresses the pitfalls in mechanical and laboratory diagnostic procedures not supported by patient listening to the patient and by adequate and painstaking examination: "No physician can possibly be prepared to say much about a human being after a first visit. There are emergency situations that require spot diagnosis but they are very rare in office practice. In most cases the physician should take much time to check, observe, and to think before making a decision as to diagnosis. 'I don't know' is often both the wisest first diagnosis that can be made and the only accurate one."

After many hours spent enjoying this book, this reviewer enthusiastically recommends it to medical student and practitioner alike, sure that everyone who gets it will read it and will find the money and the time well invested.

Carlos P. Lamar, M.D.

Recent Advances in Tropical Medicine. By Sir Neil Hamilton Fairley, K.B.E., M.D. (Lond). D.Sc. (Melb), F.R.C.P., F.R.A.C.P., D.T.M. & H (Eng), F.R.S., Hon. F.R.C.P. (Ed), Hon. M.D. (Adel), Hon. LL.D. (Melb), Hon. D.Sc. (Syd), A. W. Woodruff, M.D. (Durh), Ph.D. (Lond), F.R.C.P., D.T.M.&H. (Eng), and J. H. Walters, M.D. (Camb), F.R.C.P., Lt.-Col. I.M.S. (Ret). Ed. 3. Pp. 480. Illus. 15. London, J. & A. Churchill Ltd, 1961. Distributed in the United States by Little, Brown and Company, Boston.

Although this is a third edition of a former work bearing the same title, it has been completely rewritten. It is, in reality, a new book covering a period in which advances in the treatment and control of tropical diseases have removed many of the hazards which formerly beset the lives both of people born in temperate climates who visit or serve in the tropics, and of indigenous peoples in these regions. In view of the rapid progress in tropical medicine

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION
JAMA
VOL. 174, NO. 5 OCTOBER 1, 1960
newest J.A.M.A. paper[1] reports
DBI
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in management of diabetes . . . from the mild stable adult to the severe labile juvenile

during and since World War II, the authors have aimed to bring together within a volume of handy size the important advances which have taken place in tropical medicine, particularly during the last 10 years, and to a lesser extent since the former edition by Sir Leonard Rogers in 1929. They have considered each subject included in as comprehensive a way as possible, including etiology, epidemiology, pathology, clinical features, diagnosis and treatment, giving special attention to the formidable therapeutic weapons such as the sulfonamides and the antibiotics. It is their hope, as stated in the Preface, that the volume will be a guide to the serious student of tropical medicine, not only in dealing with patients but also in considering fundamental aspects of disease, for it is so often from these that there stems new work leading to further progress. Detailed references to all the work included have been given, for these are essential for the investigator and the advanced student of the subject.

A Synopsis of Contemporary Psychiatry. By George A. Ulett, B.A., M.S., Ph.D., M.D., and D. Wells Goodrich, M.D. Ed. 2. Pp. 309. Price, $6.50. St. Louis, The C. V. Mosby Company, 1960.

Now in its second edition, this handbook was written to fill the need for a brief, introductory text of psychiatry as a quick reference for psychiatric residents, medical and psychological interns, medical students, nurses, and others whose work in the psychiatric clinic and hospital may be for a brief period of time. Accordingly, it has been made small enough to fit in the side pocket of the clinic coat. It has been written also for the general practitioner who is having his attention increasingly directed to the psychological problems of his patients and who must, in view of the shortage of psychiatrists, often provide early care for those of his patients in whom mental illness develops. The material is organized into three general areas: history taking and diagnostic procedures, clinical syndromes, and therapeutic measures. Advances in psychiatric treatment have made necessary considerable revision of the section on therapy in this new edition. The recent discoveries in psychopharmacology have produced new opportunities and new therapeutic problems, which the authors hope will be clarified by the tabular information on the psychotropic drugs. They have attempted throughout to maintain the intended eclecticism of the original edition.

The Hand: A Manual and Atlas for the General Surgeon. By Henry C. Marble, M.D., F.A.C.S. Pp. 207. Illus. Price, $7.00. Philadelphia, W. B. Saunders Company, 1961.

This new book on the hand is designed to meet the needs of those who see hand injuries first—the general practitioner, the general surgeon and the industrial physician. Full page plates and explicit text offer instant help in treating every type of hand injury from lacerations and puncture wounds to fractures and crushing injuries. The author vividly describes and illustrates the anatomical structure of the hand, wrist and forearm, discusses applied physiology, history taking and examination, gives extensive coverage to closed injuries of the hand and their management, and discusses fully open injuries and their effective management. Complete and separate chapters cover splints and splinting, infections of the hand and tumors of the hand. The methods explained provide the best opportunity for a good functional result. The reader

(Continued on page 383)

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1. Barclay, P. L.: J.A.M.A. 174:474, Oct. 1, 1960.

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(Continued from page 381)

is alerted to pitfalls and to situations where hasty action may jeopardize the patient's chances for definitive reconstruction later. Citing data from the United States Department of Labor indicating that 77 per cent of all injuries resulting in permanent partial disability occur in the hand and fingers, the author considers the treatment of an injured hand a more exacting task than caring for most cases of acute appendicitis. He would have doctors realize the perils of hand surgery and be aware of its importance, its dangers, and its consequences.

Diabetic Care in Pictures. *Simplified Statements with Illustrations Prepared for the Use of the Patient.* By Helen Rosenthal, B.S., and Joseph Rosenthal, M.D. Ed. 3. Pp. 237. Illus. 137. Price, $4.50. Philadelphia, J. B. Lippincott Company, 1960.

The authors are members of the faculty at Tufts University School of Medicine in Boston and they follow closely the patterns set by the Joslin group. For those physicians who adhere to their philosophy this new edition is one of the best training manuals available to aid in handling their diabetic patients. The profusion of illustrations, some of them naively repetitious, but all of them clear and easily understandable by the least educated patient, explains step by step everything the diabetic must learn in relation to food, insulin and the oral antihyperglycemic drugs, blood and urine tests as well as the excellent final chapters on skin injuries, personal hygiene and care of the feet.

Even those who disagree with certain tenets of the Boston school will find this book useful and time-saving in the instruction of diabetic patients as the various points of disagreement are not difficult to point out and explain with good reasons for their difference of opinion. In this reviewer's opinion the most objectionable feature is the high content of fat in the sample diets. The diet featured for adults contains 42 per cent of the total calories in animal fats, the one for children about 35 per cent. When the smoke of the battle of cholesterol is already clearing and the evidence in favor of at least moderately sensible restrictions in saturated fats has become so overwhelming that the "old guard" in the American Heart Association is already throwing the towel and accepting the undeniable facts and the enormous statistical evidence, it is a pity that the authors did not do it and continue favoring the meat and dairy industry with their recommendations for diets with plenty of animal fats. As up to now the period of time between editions has been seven years, this particular item in the book seems to be destined to long obsolescence. Despite this easily correctable point, the book in general is good, and I intend to recommend it to those of my patients in need of such detailed information.

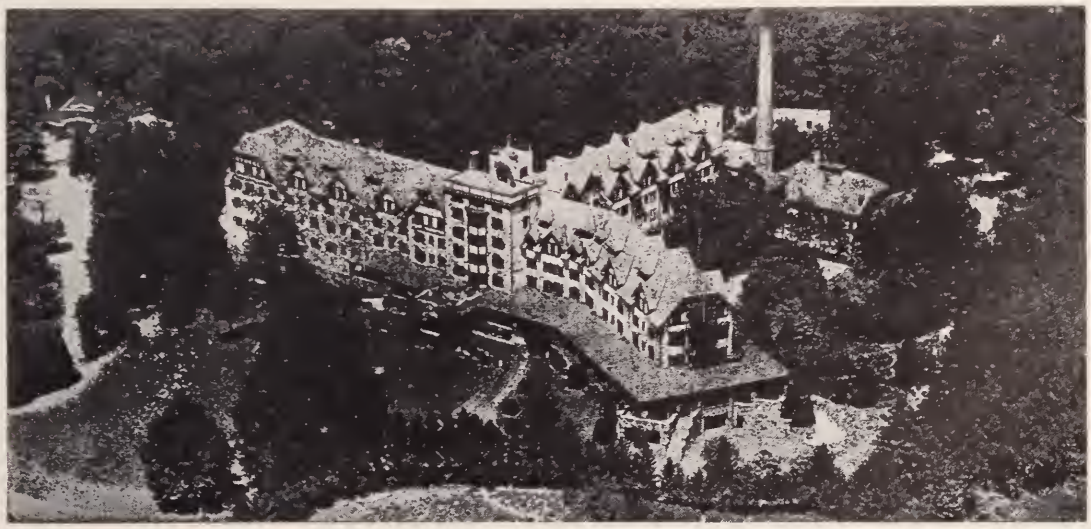
Carlos P. Lamar, M.D.

Current Therapy—1961. Latest Approved Methods of Treatment For The Practicing Physician. Edited by Howard F. Conn, M.D. Pp. 806. Price, $12.50. Philadelphia, W. B. Saunders Company, 1961.

Each year, Current Therapy is essentially a new book. In the 1961 volume 314 authorities contribute, offering the most effective therapeutic methods in use today—whether they are newly developed treatments or older methods whose results are still the most satisfactory. Of the 307 articles in this year's volume, 253 reflect advances in the management of disorders—new drugs, new methods, improvement in technique, and in some cases, a completely new regimen. All of the articles are written especially for this book. The information presented is not in any way experimental nor is it prejudiced in favor of any special drug or method. This popular annual volume offers methods of management for over 400 commonly encountered diseases and disorders. New topics include: acute pulmonary embolism, cardiac arrest, fungal endocarditis, chronic leukemias, staphylococcal enterocolitis,

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carotid artery disease, intracerebral hemorrhage, and emphysema. Here is an up-to-the-minute review of therapy diverse in scope, but specific in recommendations.

Moloy's Evaluation of the Pelvis in Obstetrics. By Charles M. Steer, M.D., Med. Sc.D., F.A.C.O.G. Ed. 2. Pp. 131. Illus. 57. Price, $4.00. Philadelphia, W. B. Saunders Company, 1959.

The intention of this monograph is not to compete with the large textbooks of obstetrics but instead to familiarize the physician with the type of delivery designated to the individual case. The author is modest in sharing credit with contemporaries while the work is his labor. The various female pelvic contours are discussed in detail with the aid of numerous excellent drawings, photographs and comparative diagrams. These variances are reciprocally related with their effect upon labor which helps determine certain obstetrical prognoses. Emphasis is placed upon the technique of examination which includes the importance of clinical data and roentgenological evidence, and leaves little to intuition. Since difficult labor is the important problem in obstetrics and pelvic disproportion is the main cause for this, various cephalopelvic disproportions are reviewed and therapies summarized. The intern, resident and practitioner would benefit by equipping himself with this compact monograph on the mechanics of labor.

Clifford C. Snyder, M.D.

Pharmacology: The Nature, Action and Use of Drugs. By Harry Beckman, M.D. Ed. 2. Pp. 805. Illus. 117. Price, $15.50. Philadelphia, W. B. Saunders Company, 1961.

This new second edition of a book previously titled DRUGS: Their Nature, Action and Use is more comprehensive in coverage and has been meticulously brought up to date throughout. The author expertly describes the pharmacologic properties and actions of all significant drug agents in current use. Each is classified according to the body function it affects. The nature of all ascertained actions is concisely stated in each case. Types and degrees of toxicities are clearly set forth with appropriate warnings of possible poisoning or side effects. Individual drugs within classes are compared one to the other from the standpoints of actual or potential usefulness. Dosage schedules are provided for the use of particular drugs under varying circumstances. Coverage progresses according to logical and meaningful physiologic units. Among a number of new chapters added to this edition are those on Unwanted Responses to Drugs, Drugs Used Principally for Vasodilation in Peripheral Vascular Disease, Drugs Beneficial in Hepatic Coma, and Drugs Used to Treat Atherosclerosis. The latest advances in the use of such fast-changing agents as the tranquilizers, energizers, antibiotics, diuretics, and analgesics are all included. Checking over this new edition will help greatly in sorting the conflicting claims of today's pharmacologic scene.

W. B. SAUNDERS COMPANY features the following recent books in its full page advertisement appearing elsewhere in this issue:

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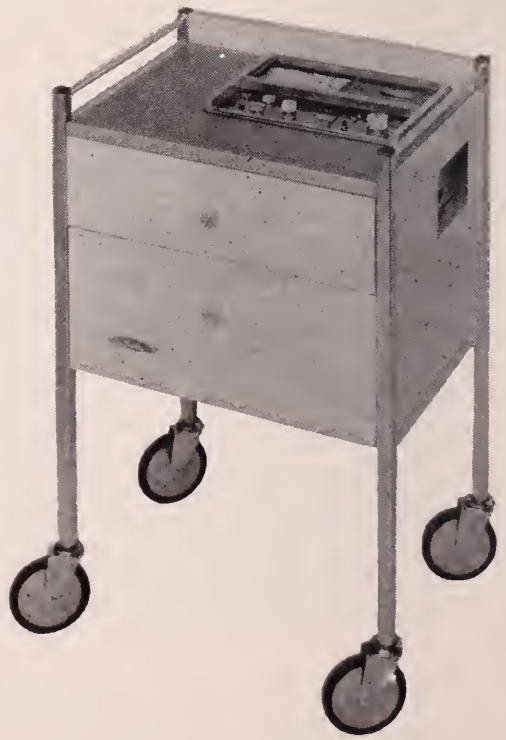
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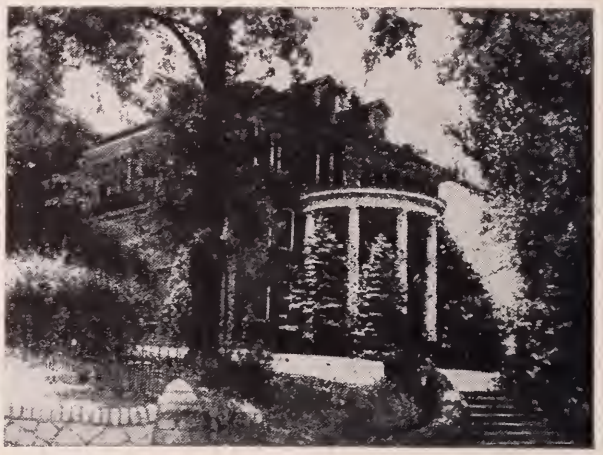
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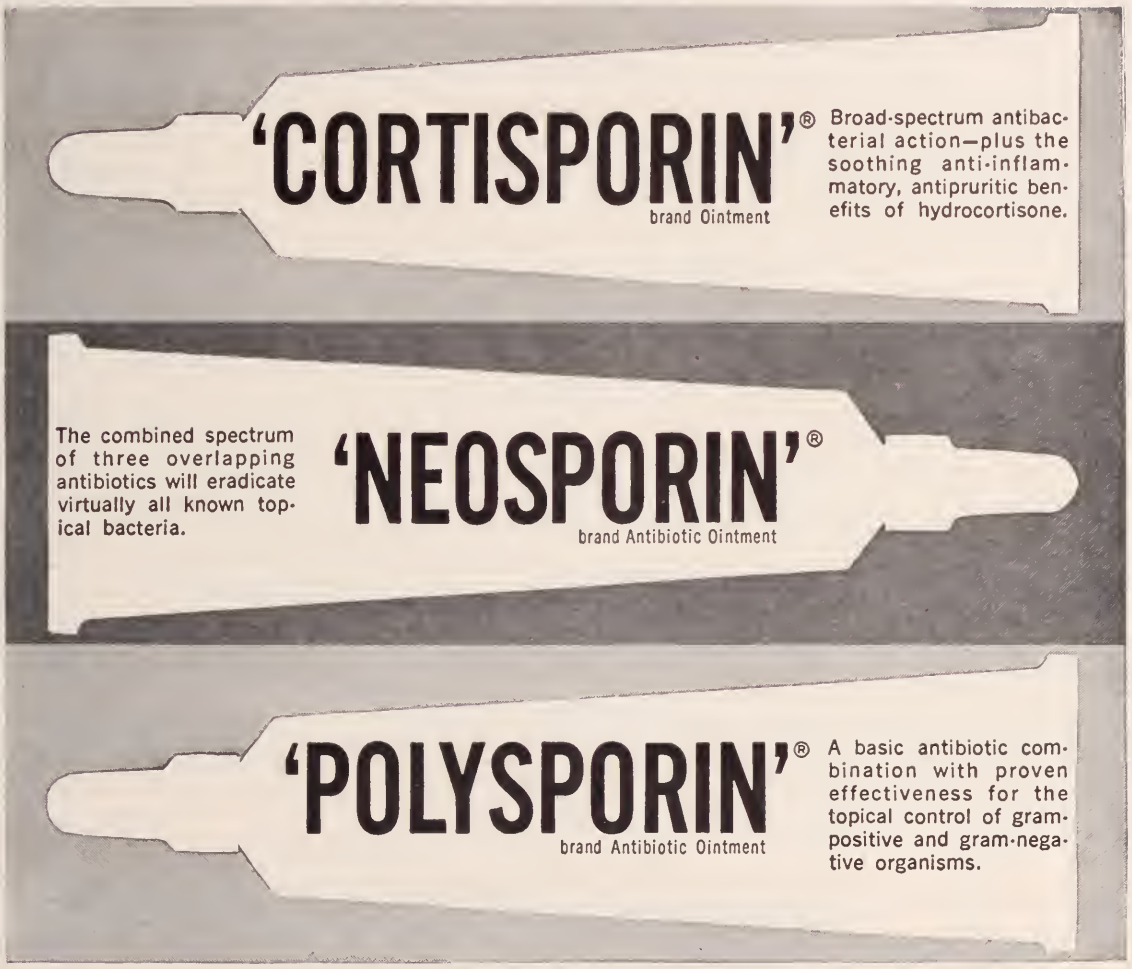
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continuous, 24-hour cerebral oxygenation for the aging patient. By stimulating respiratory and circulatory function, GERONIAZOL TT* relieves mental confusion, depression, anxiety, and emotional instability—frequent problems in patients after forty—due to presenile changes in the vasculature of the brain. Notable benefit usually is seen within one to three weeks of therapy. It improves appetite, sleep pattern, and outlook—and GERONIAZOL TT* is non-hypertensive, non-excitatory.

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References: 1. Curran, T. R., and Phelps, D. K.: Am. Pract. & Dig. Treat. *11:* 617, 1960. 2. Levy, S.: J.A.M.A. *153:* 1260, 1953. 3. Connolly, R.: W. Va. Med. J. *56:* 263, 1960.



Each TEMPOTROL contains: Pentylenetetrazol, 300 mg.; and Nicotinic Acid, 150 mg.

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Supplied: Bottles of 42 tablets (3 weeks' treatment).

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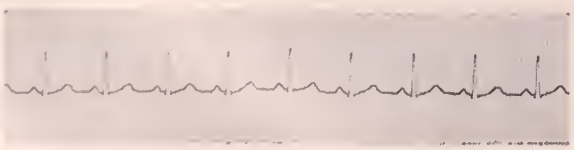
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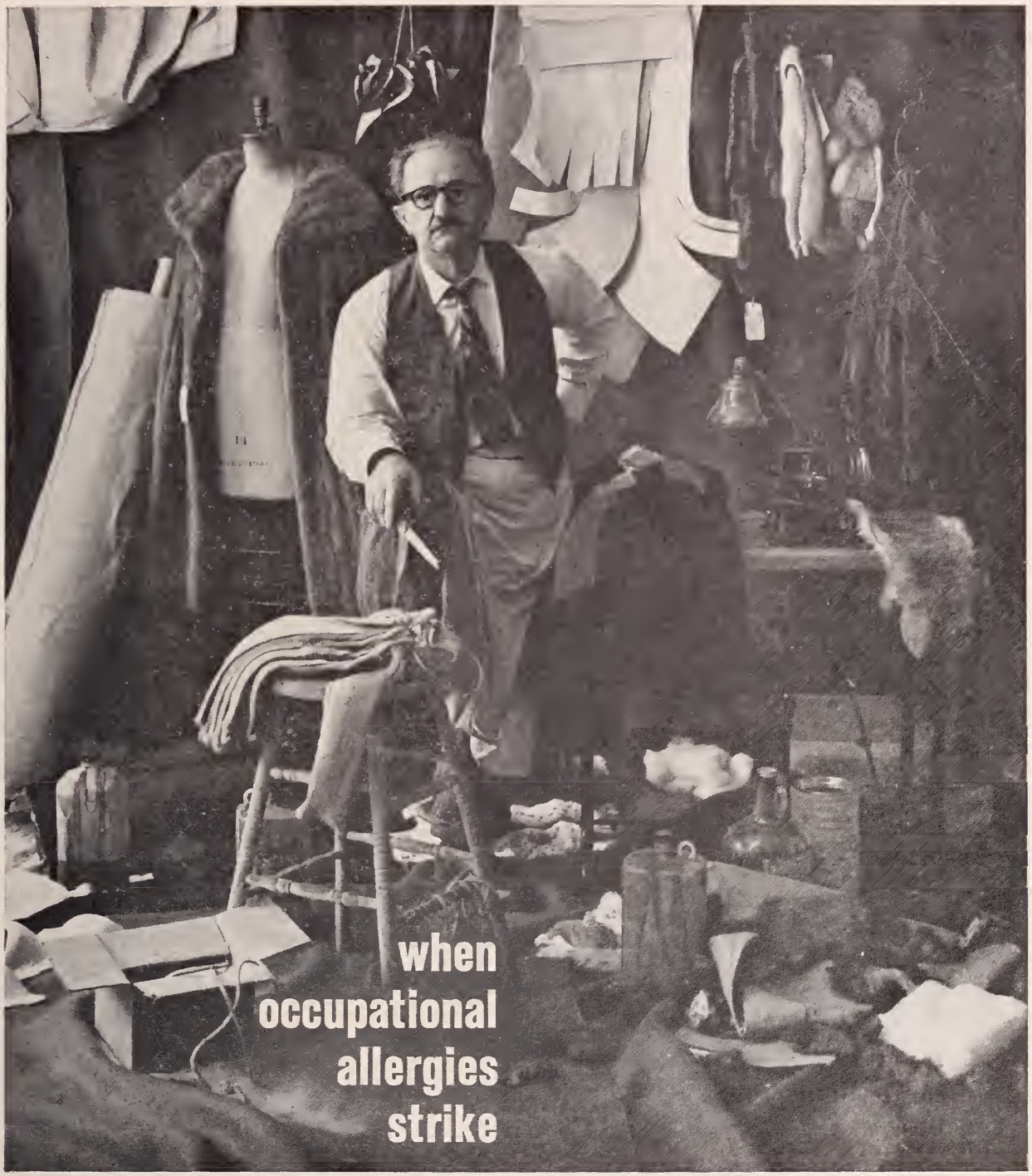
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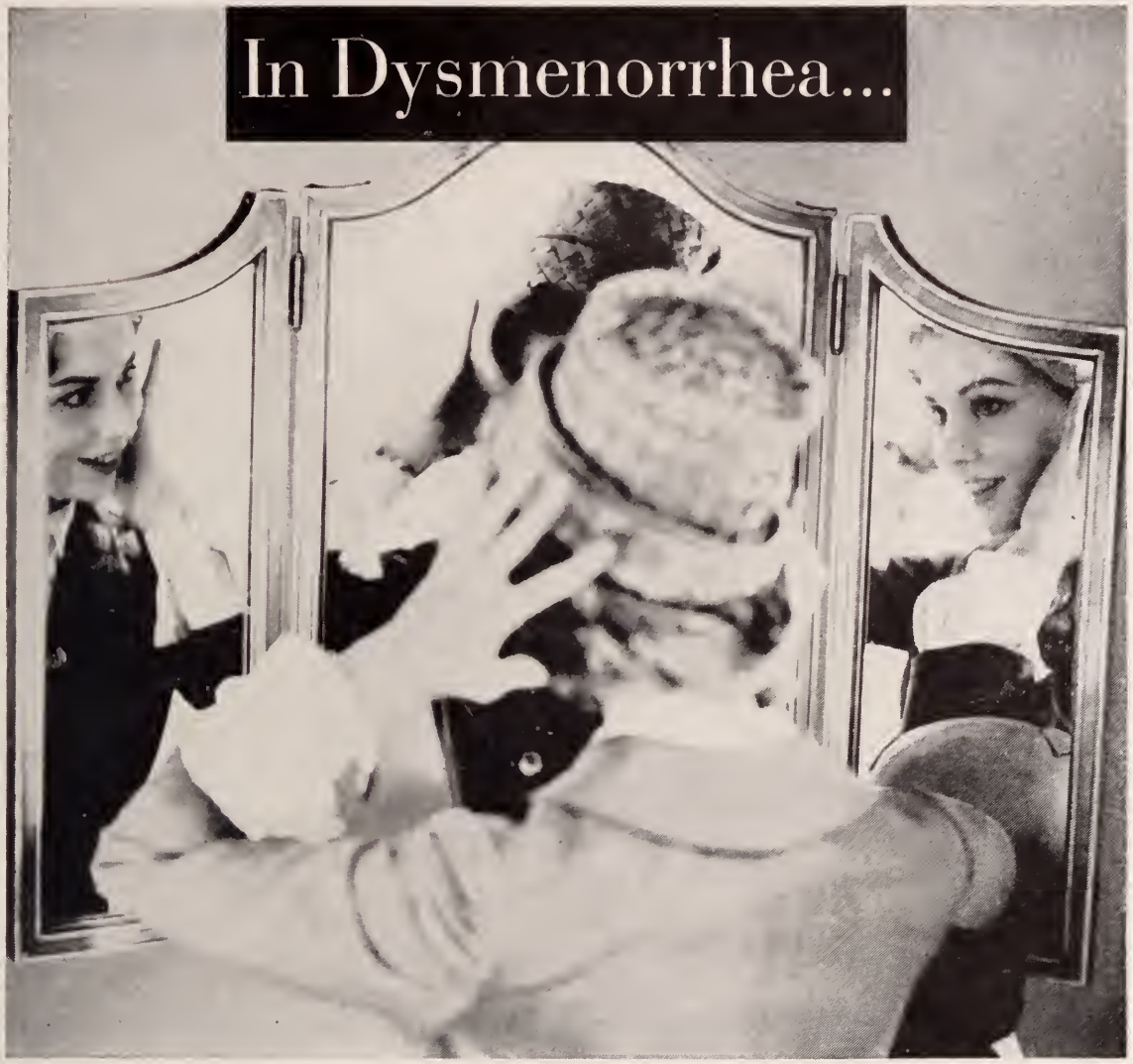
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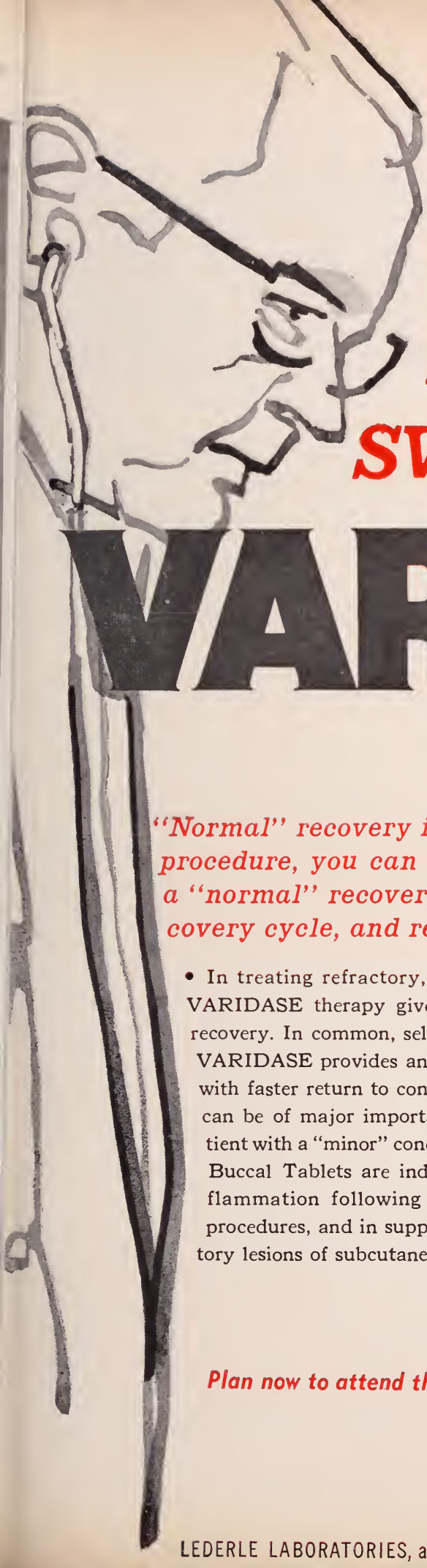
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do all you can whenever there is local inflammation/swelling/pain...

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drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

Albert H. Holland, M.D.
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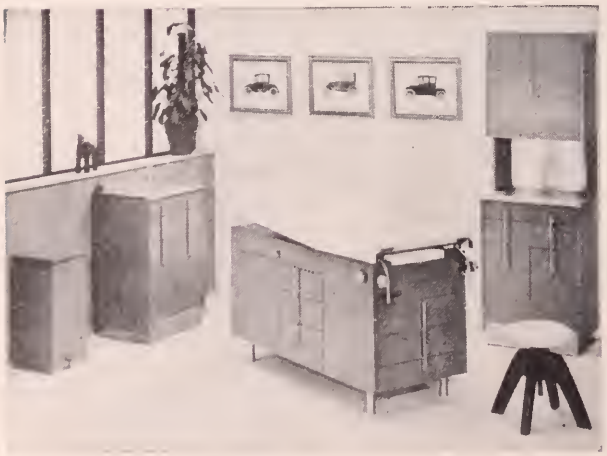
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Panalba*

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Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.

SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.

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CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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an added measure of protection for little patients

against relapse
against "problem" pathogens

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DEMETHYLCHLORTETRACYCLINE LEDERLE

pediatric drops
syrup

● full antibiotic activity ● lower milligram intake per dose ● up to 6 days' activity with 4 days' dosage ● uniformly high, sustained peak activity ■ **syrup** (cherry-flavored), 75 mg./5 cc. tsp., bottles of 2 and 16 fl. oz. Dosage: 3 to 6 mg./lb./day—in four divided doses. **pediatric drops,** 60 mg./cc., 3 mg./drop, 10 cc bottles with calibrated dropper. Dosage: 1 to 2 drops/lb./day—in four divided doses.

PRECAUTIONS: As with many other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patient should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs discontinue medication. Overgrowth of nonsusceptible organisms is possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

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satisfactory results in 88% of cases

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How to help your patient stick to a low fat-cholesterol diet

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A glass of beer can add zest to a patient's diet

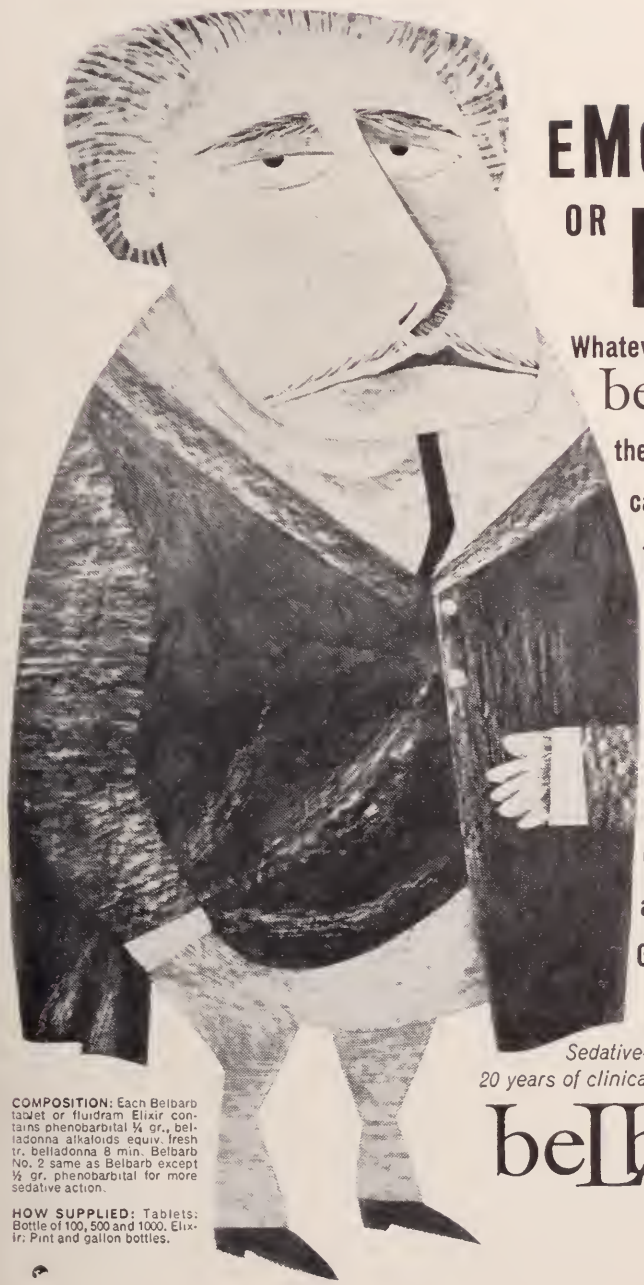
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New 4% Xylocaine® HCl applied topically to the larynx, pharynx, and trachea, gives fast, intense and profound anesthesia for endoscopic procedures. Whenever effective anesthesia of the mucosa of the eye, ear, nose and throat is required, topical Xylocaine HCl 4% offers all these advantages ▪ fast anesthetic action ▪ intense depth of anesthesia—not just surface analgesia ▪ effectiveness in small volumes—average 4 cc. ▪ patients experience no pain ▪ relatively nonirritating and nonsensitizing ▪ side effects are extremely rare. In ophthalmology, Xylocaine HCl 4% used both topically and by retrobulbar injection, provides fast, deep, and enduring anesthesia for a wide variety of major as well as minor surgical techniques. Xylocaine® HCl (brand of lidocaine*)

Administration and Dosage: For topical anesthesia, Xylocaine HCl 4% may be applied as a spray or with cotton applicators or packs, and by instillation into a cavity. The suggested volume ranges, for adults, from one to five cc. (40-200 mg.). For children, debilitated and aged patients, dosages should be proportionately reduced. Prior to removal of foreign bodies from the eye, examination of corneal lacerations, cauterization of corneal ulcers, and other surgical and diagnostic procedures, 2 to 3 drops of Xylocaine HCl 4% will usually produce adequate anesthesia. *How Supplied:* For Transtracheal and Retrobulbar Injection and Topical Application—Sterile aqueous solution dispensed in 5 cc. color-break ampules, packed 10 ampules to a carton. For Topical Use Only—Aqueous solution in 50 cc. screw cap bottles, individually cartoned.

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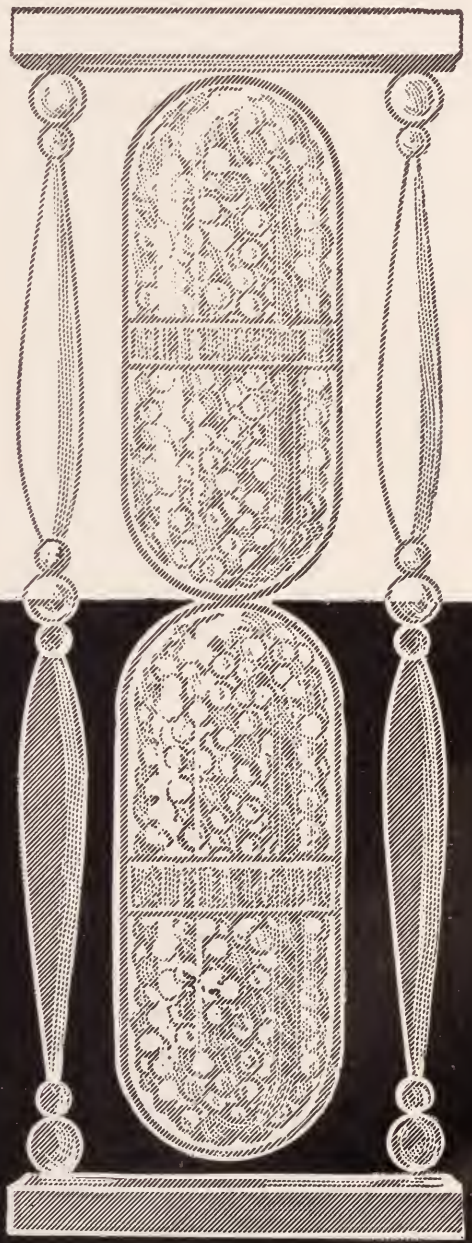
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Only 2 Pelsules Daily

Maintenance Dose

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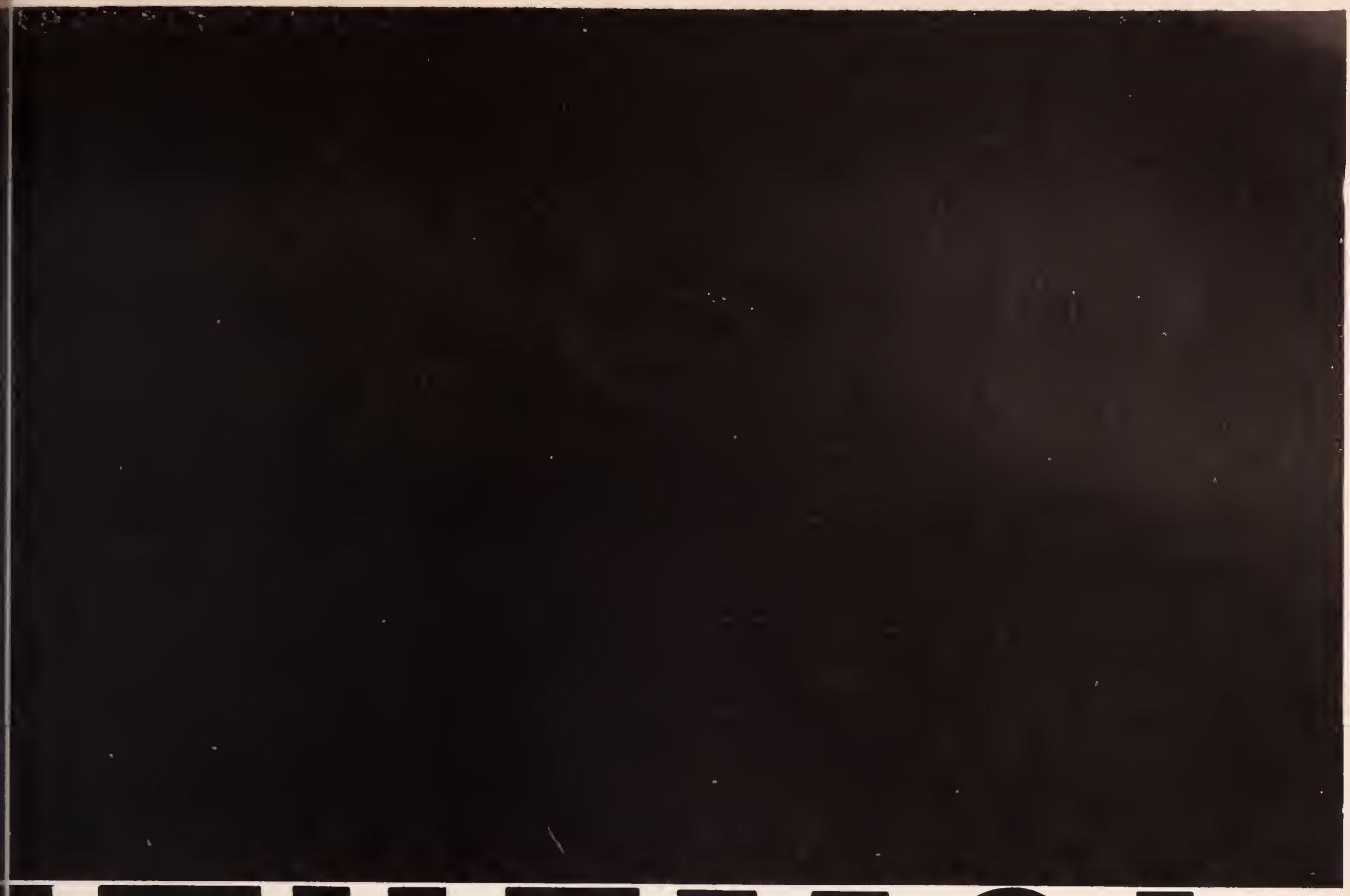
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(1) Buck, R. C.: Minerals of Normal and Arteriosclerotic Aortas, Arch. Path., 51, 1951. (2) N. Ressler, et al.: Relation of Serum Stability to the Development of Arteriosclerosis, Amer. J. Clin. Path. vol. 24, 1954. (3) S. D. Jacobson, M.D., Wayne County General Hospital, Eloise, Michigan. To be published. (4) Prof. V. Patzelt, Untersuchungen uber die Veranderunger der Bluteiweisz-Korper mit Mag. 3, 7-dimethyl-xanthine oleate, Klin. Med. 5, 11, 1956. (5) Dr. J. Skursky, Wiener Med. Wochenschrift, 1953, Nr 46, S. 886-887. (6) Eduard Keeser, M.D. and K. F. Benitz, M. D., Med. Klin. 1953 Nr. 15.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

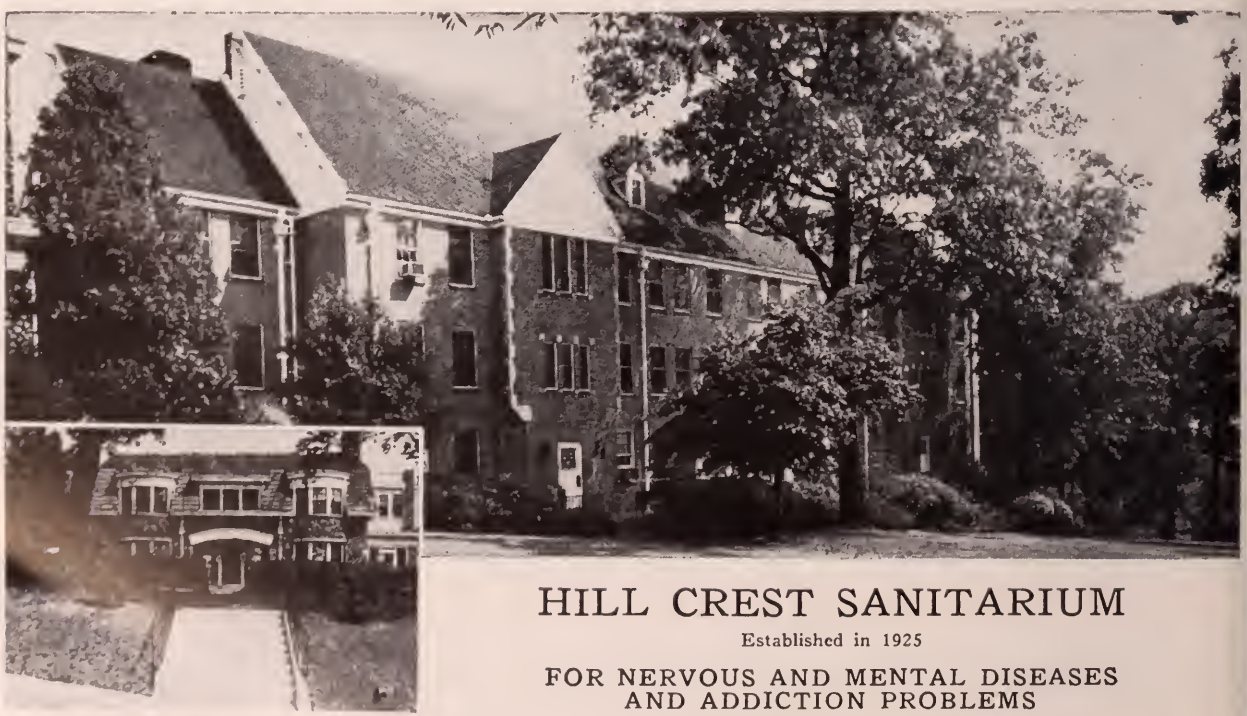
infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8. 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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1. Kane, S.: Am. Pract. & Digest Treat. *8*:65 (Jan.) 1957.

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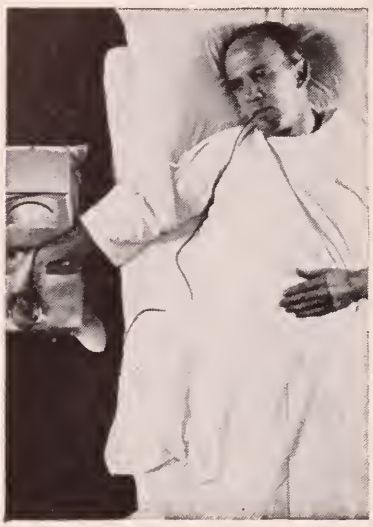
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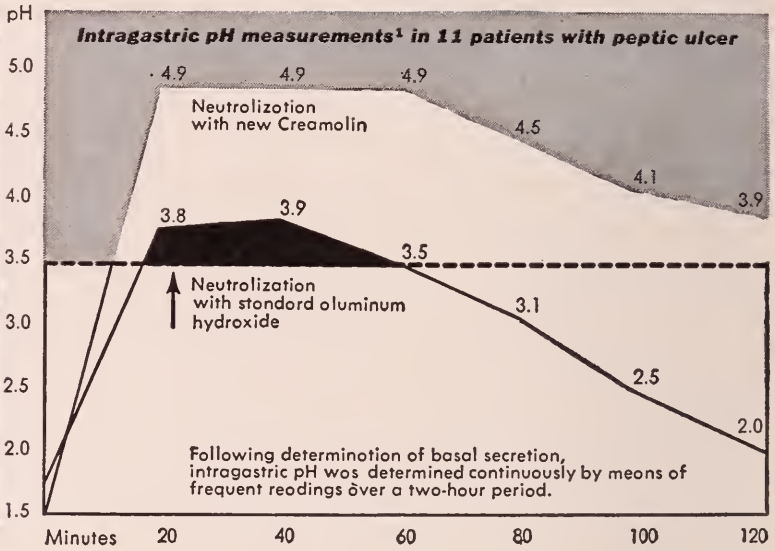
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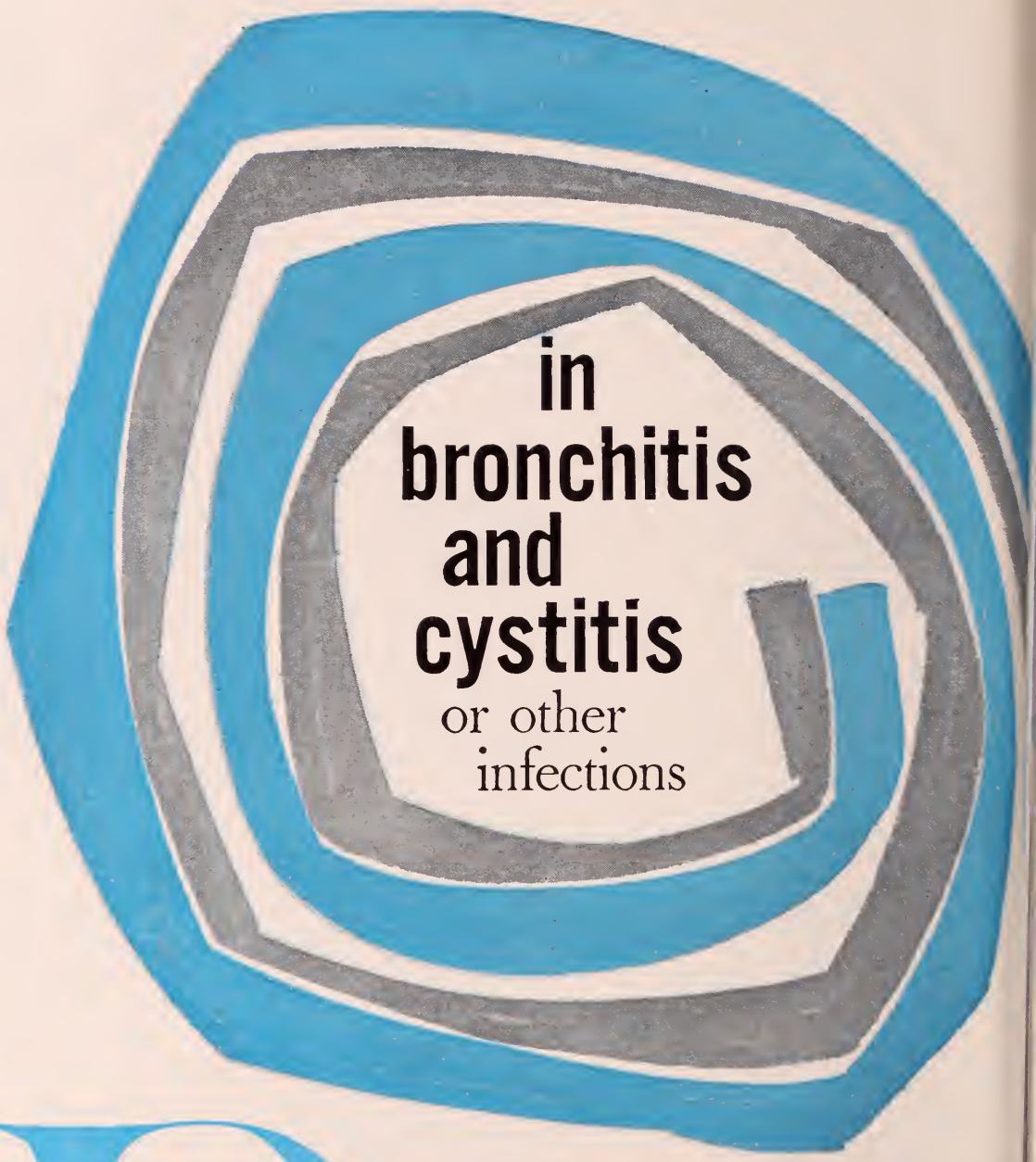
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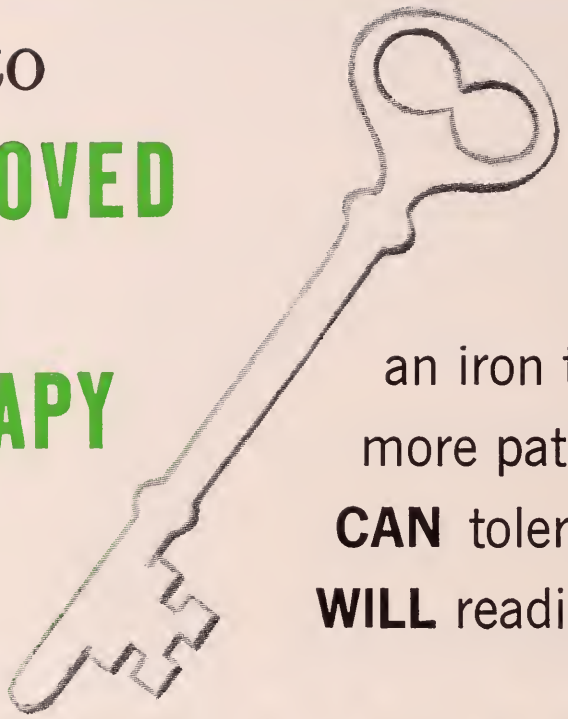
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Sunday, December 10, 1961
The Holiday Inn

Plans for 1962 already include the following Symposia, with more being arranged:

MOBILE, ALABAMA
Friday, January 5, 1962
The Admiral Semmes Hotel

ST. PAUL, MINNESOTA
January 8, 1962
The Hotel Lowry

PORTLAND, OREGON
Wednesday, January 24, 1962
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 24, 1962
The Westward Hotel

WINCHESTER, VIRGINIA
Wednesday, March 14, 1962
The Lee-Jackson Hotel

SIOUX CITY, IOWA
Thursday, March 15, 1962
The Sheraton-Martin Hotel

SPOKANE, WASHINGTON
Saturday, June 2, 1962
The Davenport Hotel

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A single non-toxic compound, SILAIN acts physically with no effect on gastrointestinal motility.

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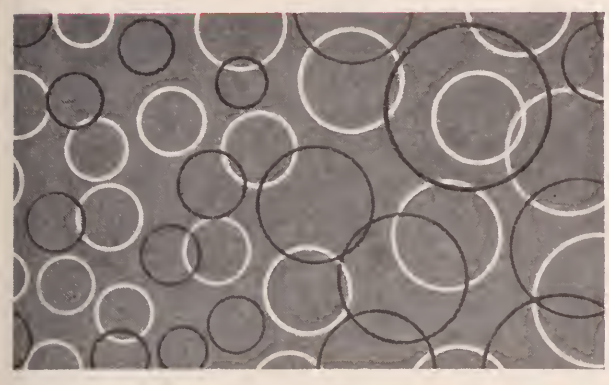
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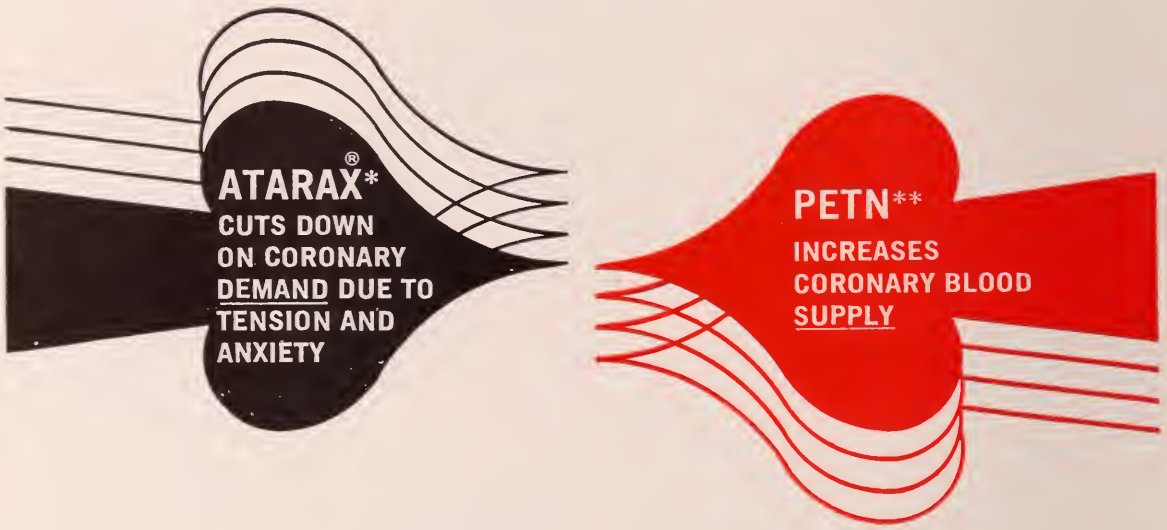
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Supplied in bottles of 100. Prescription only.

1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

*brand of hydroxyzine **pentaerythritol tetranitrate

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Panalba* promptly

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In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical.

A rational clinical alternative is to launch therapy at once with Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.
SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, and a few cases of leukopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.
CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.
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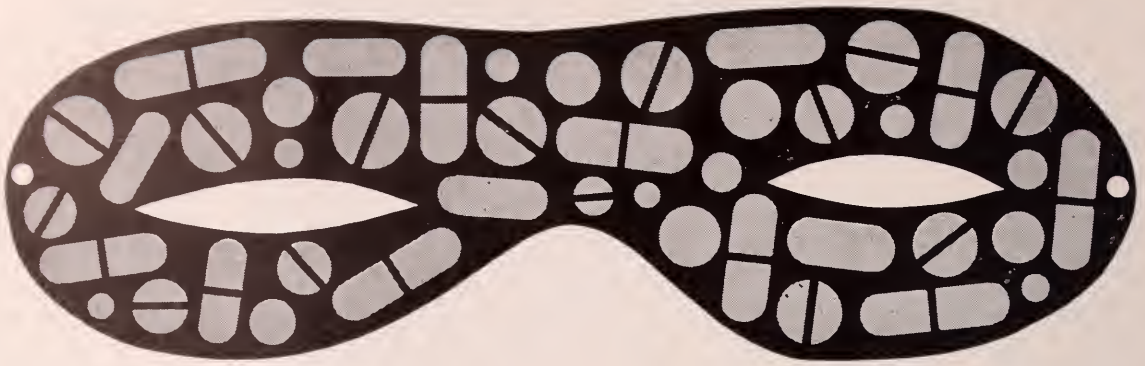
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"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

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For dependable pain relief in labor, Demerol is unsurpassed in effectiveness and safety for both mother and child. Usual dosage is from 50 to 100 mg. subcutaneously or intramuscularly when pains become regular, repeated three or four times at intervals of from one to four hours as needed.
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Increasingly...
the
trend is to

Terramycin®

OXYTETRACYCLINE WITH GLUCOSAMINE

confirmed dependability in otitis media is just one reason why



*New evidence** demonstrates the effectiveness of Terramycin in *otitis media* . . . another reason for the trend to Terramycin.

In a series of 41 cases of otitis media, Terramycin not only "was often successful where other antibiotics had failed," but also showed that "it is extremely well tolerated"; oral dosage for infants was 250 to 375 mg. daily, for children, 500 mg. to 1 Gm. In many instances, oral therapy was preceded by intramuscular injection of Terramycin.

The authors concluded that "there is good reason to consider it [Terramycin] one of the most effective agents for treatment of infection of the upper respiratory tract."

These findings confirm the continuing vitality and broad-spectrum dependability of Terramycin, as reported through more than a decade of extensive clinical use.



In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

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250 mg. and 125 mg. per capsule—for convenient initial or maintenance therapy in adults and older children

TERRAMYCIN Intramuscular Solution—
50 mg./cc. in 10 cc. vials; 100 mg. and 250 mg. in 2 cc. ampules—preconstituted, ready to use where intramuscular therapy is indicated

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*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

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88.3% 317 patients	Acute Streptococcus Pharyngitis*
95.3% 85 patients	Bronchitis* (Bacterial Complications)
88.6% 166 patients	Pneumonia*

*References supplied on request.

The usual dosage for infants and for children under twenty-five pounds is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours.

For adults and for children over fifty pounds, the usual dosage is 250 mg. every six hours.

In more severe or deep-seated infections, these dosages may be doubled.

Ilosone is available in three convenient forms: Pulvules®—125 and 250 mg.†; Oral Suspension—125 mg.† per 5-cc. teaspoonful; and Drops—5 mg.† per drop, with dropper calibrated at 25 and 50 mg.

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION
Volume XLVIII, No. 5, November, 1961

Chemotherapy in Juvenile Cancers

HAROLD W. DARGEON, M.D., JOSEPH H. BURCHENAL, M.D.
M. LOIS MURPHY, M.D. AND CHARLOTTE TAN, M.D.
NEW YORK CITY

The number of chemotherapeutic agents of demonstrated, even though temporary effectiveness in the control of juvenile cancer increases each year. It would be premature to assume that a permanently curative drug or combination of drugs will soon be available. The accumulated encouraging experiences, however, with cancer chemotherapy from many parts of the world during the last 15 years suggest that such a goal may be attained before the end of the century. Meanwhile, the understandable enthusiasm for these agents by investigators and clinicians who treat malignant diseases should not deny the child the full opportunity of treatment by the traditional and perhaps curative modalities of surgery and radiotherapy.

Cancer chemotherapy is not new, but the resurgence of interest in it following the observations reported in 1946 by Gilman and Philips,[1] on the use of (tris) beta chlorethylamine hydrochloride has rapidly increased. Initially and for several years thereafter the usefulness of the chemotherapeutic compounds was largely restricted to the treatment of lymphomas. At the present time additional agents are available for use as adjuvants to conventional therapy for some of the hitherto refractory tumors of children (fig. 1).

Since the effects of these agents are due to disturbances in cellular metabolism and are mediated in various ways—humoral, by interference with nucleic acid synthesis, and by mitotic arrest—the combined use of these drugs is sometimes indicated.

The effects of numerous compounds and investigational methods on a large variety of children's tumors have been studied by many observers. The agents and procedures investigated include fluorinated pyrimidines, vitamin B_{12}, sex hormones, arsenicals, urethane, Coley's toxins, Mytomycin C, Streptonigrin, Vincaleukoblastine, total body irradiation followed by isologous marrow infusion, radioisotopes, and intra-arterial perfusion of alkylating and antimetabolic agents.[2] The encouraging results achieved at times in some osteogenic sarcomas, Ewing's sarcomas, retinoblastomas, and embryonal rhabdomyosarcomas indicate the need for further exploration.

This discussion will be limited to a review of our experiences with compounds of proved value in the treatment of lymphomas, Wilms's tumors, neuroblastomas, and nonlipid reticuloendotheliosses. The last named entity is included because in some of its histologic as well as clinical manifestations, this condition is indistinguishable from cancer.

The therapeutic attack on any disease demands consideration of the patient as a whole and the relationship of the morbid process to his total economy. The physical and psychologic effects of cancer on the child are appreciated by all clinicians, and their treatment prior to, during, and following all forms of cancer therapy is of major importance. Since many children have associated

From the Department of Pediatrics and the Chemotherapy Service, Memorial Sloan-Kettering Cancer Center, New York City.
Read in part before the Florida Medical Association, Eighty-Seventh Annual Meeting, Miami Beach, May 27, 1961.

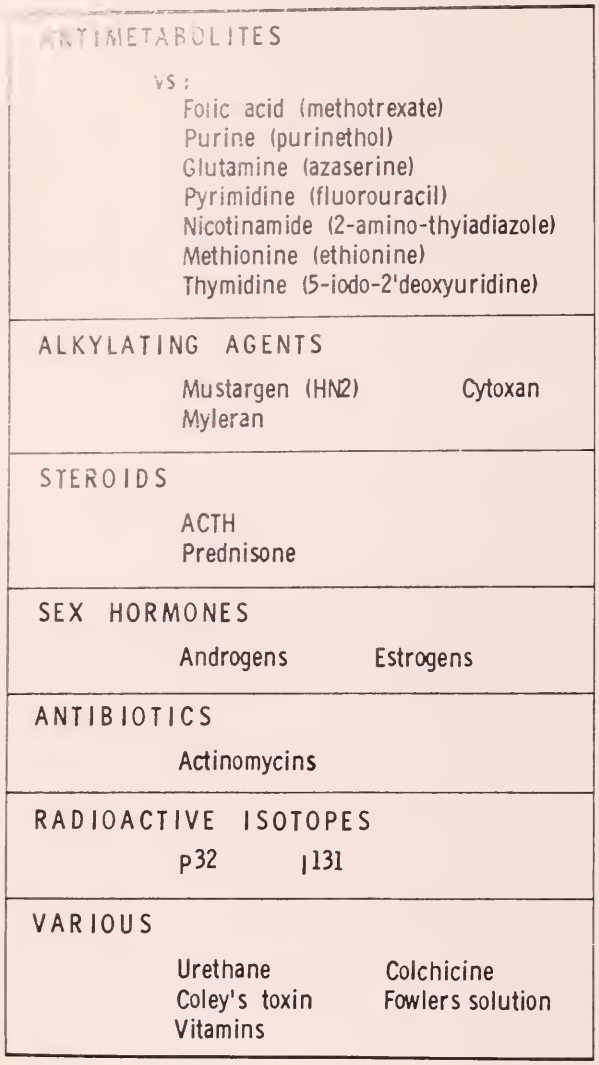


Fig. 1.—Agents used in cancer chemotherapy.

nutritional, hematopoietic, and recurrent infections, the management of such concurrent problems becomes a constant challenge.

Leukemia

ACUTE LEUKEMIA

Steroids: Oral: Prednisone: 40 to 100 mg. daily in divided dosage (10 to 25 mg. q. 6 h.)

Prednisolone or methylprednisolone: 30 to 80 mg. daily in divided dosage (6 to 20 mg. q. 6 h.)

Intravenous: ACTH: 5 U. to 25 U. daily (continuous drip).

Prednisolone or methylprednisolone: 40 to 100 mg. daily (continuous drip).

Note: Hyperuricemia and hyperuricosuria are hazards to be carefully avoided in the use of steroids, particularly in "high count" leukemias and in those with large infiltrations into lymph nodes or viscera. Hydration is therefore imperative *before* the drugs are started. The dose of the steroids during the first 24 hours should be kept very low, until the effects of these drugs on the uric acid output can be determined.

Maintenance Therapy: After a short course of steroids antimetabolites are substituted, the steroids being gradually reduced while the antimetabolite dosage is being established.

Antimetabolites:

6—Mercaptopurine (Purinethol)

Oral: 2.5 mg./kg. daily.

Methotrexate:

Oral: 1.25 to 5 mg. daily.

Intrathecal: 0.25 mg./kg. every five days for three to four doses.[3]

Alkylating Agents:

Cyclophosphamide (Cytoxan)

Intravenous: 1.25 to 2.5 mg./kg./day (continuous drip).

Oral: 2.5 to 5 mg./kg./day.

Intravenous or oral dosage is continued until there is a leukopenia of 1,000 to 2,000 cells per cubic millimeter. Preliminary studies of this compound in 28 patients who had become refractory to other drugs showed a marrow remission in 32 per cent. In one instance the remission lasted four months after initiation of therapy.

Radiotherapy: Local radiation to sites such as kidneys, liver, and central nervous system is sometimes required.

Results: Acute leukemia, 1952-1959:

Number of patients treated	*Survival from onset*
370	50 per cent> 12 mos.
	10 per cent> 22 mos.

CHRONIC GRANULOCYTIC LEUKEMIA*

Myleran: 2 to 4 mg./day, orally. Discontinue temporarily when the leukocyte count is 60,000 per cubic millimeter. Observe platelet count at this time regularly for it may continue to fall after the leukocyte count has become stabilized.

6—Mercaptopurine (Purinethol): 2.5 mg./kg. daily, by mouth.

LYMPHOSARCOMA

First the possibilities of radiotherapy and surgery should be exhausted.

Alkylating Agents:

Mustargen (nitrogen mustard): 0.4 mg./kg. intravenously, and divided into four doses of 0.1 mg./kg., or in a single dose. In acute

*Radiotherapy to the spleen should be considered before chemotherapy in this disease.

obstructive tracheal compression this drug may be used initially in preference to radiotherapy, which, however, should be given subsequently.

Chlorambucil (Leukeran): 0.1 to 0.2 mg./kg./day, by mouth.

Cytoxan: 5 mg./kg./day, by mouth.

Myleran: 2 to 4 mg. daily, by mouth.

Steroids and antimetabolites have also been used by us, empirically to be sure, on a "cyclic" routine, following conventional surgery or irradiation.[4] The value of this procedure cannot be determined at this time. It has seemed reasonable to try to increment the effect of irradiation and possibly to arrest clinically unrecognizable sites of lymphosarcoma by using drugs that are known temporarily to produce clinical remissions. Furthermore, since in our own experience in 20 per cent of 96 children with an initial diagnosis of lymphosarcoma, leukemia developed, perhaps a deterrent effect of this fatal outcome could be achieved by using antileukemic drugs prior to the climical manifestations of leukemia.

Hodgkin's Disease

Stage 1. Localized lesion:

Mustargen: 0.4 mg./kg., administered intravenously as an adjuvant to conventional treatment.

Stage 2. Regional lesions, that is, all lesions above or below the diaphragm with or without systemic symptoms:

Mustargen: 0.4 mg./kg., administered intravenously as an adjuvant to radiotherapy.

Stage 3. Disseminated lesions:

Mustargen: 0.4 mg./kg., given intravenously with radiotherapy to bulky sites.

Leukeran: 0.1 to 0.2 mg./kg./day, orally.

Cytoxan: 5 to 10 mg./kg./day, orally.

Actinomycin D: 15 mcg./kg. daily, given intravenously for five days.

Wilms's Tumor

Localized: Surgery, if feasible.

Radiotherapy: 2,000 r to tumor bed postoperatively.

Actinomycin D: 15 mcg./kg./day intravenously for five days to a total of 75 mcg./kg. This course is given after radiotherapy.

Metastatic: Radiotherapy to primary tumor, 2,000 r in two weeks.

Surgical removal of tumor if the child's condition permits.

Actinomycin D: 15 mcg./kg./day intravenously postoperatively for five days.

Radiotherapy to metastatic sites.

Actinomycin D: 15 mcg./kg./day intravenously at three month intervals if a response is obtained. If the response is unsatisfactory, use triple combination therapy.

Actinomycin D: 15 mcg./kg./day for five to seven days, intravenously.

Cytoxan: 5 mg./kg./day intravenously for five to seven days.

Methotrexate: 2.5 mg. orally, given daily for five to seven days.

Neuroblastoma

Localized: Surgical removal, if possible. The question of partial removal or major surgical insult, as advocated by Koop, Kiesewetter and Horn,[5] must at present be left to the discretion of the surgeon. The technical difficulties of resection in many of the children with neuroblastoma discourage some surgeons from this approach.

Radiotherapy: 2,000 r in two weeks to the primary tumor if not resectable. Also postoperatively, unless the surgeon believes no disease remains.

Mustargen: 0.4 mg./kg. intravenously in a single dose is given during the radiotherapy, or as soon after its completion as possible, if the child's condition permits. It is sometimes feasible to operate after this program.

Metastatic: Radiotherapy: 2,000 r in two weeks to presumed primary site. Possible radiotherapy to metastatic sites.

Mustargen: 0.4 mg./kg. intravenously, in a single injection, or

Actinomycin D: 15 mcg./kg. daily for five days, given intravenously.

Surgery: In some metastatic cases surgical resection may be considered.

The appraisal of the value of all forms of therapy for neuroblastoma must be based on an appreciation of the variable natural history of this disease and on the unpredictable beneficial results sometimes observed, even when treatment appears inadequate.[6]

Nonlipid Reticuloendotheliosis

Eosinophilic granuloma, Hand-Schüller-Christian disease, and Letterer-Siwe disease are in-

cluded under this classification. They are believed to be related, or perhaps variants of the same basic disorder.[7] In some instances they are indistinguishable histologically and may pursue an unexpectedly benign or serious clinical course. The microscopic appearance of the typical Letterer-Siwe tissue specimen is that of an aggressive, malignant process; in certain instances in our experience the same lesion has been diagnosed as eosinophilic granuloma, Hand-Schüller-Christian disease, and Letterer-Siwe disease by pathologists of equal competence.

The problem confronting the clinician is whether the varieties apparently benign on histologic evidence are so in fact. The dissemination of lesions benign by current anatomic standards and the progressively declining clinical course of the disease in several children whose lesions were initially diagnosed as eosinophilic granuloma suggested that systemic agents were indicated.

Since 1948, all of our juvenile patients have received chemotherapy, usually as an adjuvant, or following surgery and irradiation, until the clinical course of the disease could be determined.

The corticosteroids, ACTH, alkylating agents, and antimetabolites may be expected at least temporarily to produce beneficial results in most instances. In several patients remissions, at present lasting over 10 years, have been achieved by the cyclic use of antimetabolites alone. One girl, now 14 years old, whose condition during infancy was initially diagnosed as eosinophilic granuloma is considered by some authorities, including Professor Letterer, to have had Letterer-Siwe disease. Antituberculous drugs, first described by Aronson,[8] have also been used in refractory cases in conjunction with antimetabolites. Two of four patients have had arrest of their disease for over two years.

Toxicity and Side Effects

Chemotherapeutic compounds for the conditions mentioned should not be used in the absence of a positive diagnosis and only then if close medical supervision can be maintained. There may be considerable variation in the response to the drugs, not only of the disease, but also of the patient. Toxicity may precede clinical improvement, and irreversible disturbances sometimes may occur from overdosage.

The following are some of the common toxic effects observed in children. The more subtle humoral and immunologic effects can only be suspected.

Methotrexate: Gastrointestinal ulcerations, marrow depression, megaloblastosis.

Purinethol: Rapid decline in white blood cells in high count leukemias; possible hyperuricemia and hyperuricosuria.

Prednisone: Cushing's syndrome; hypertension; hyperglycemia; psychic disturbances; reduced resistance to infection; hyperuricemia; hyperuricosuria.

Mustargen, Leukeran, Myleran, Cytoxan: Marrow depression; anorexia; nausea, vomiting with Mustargen; alopecia; hemorrhagic cystitis with Cytoxan.

Actinomycins: Marrow depression; oral ulcerations, dermatitis, especially at sites of previous radiotherapy; alopecia.

Summary

The value of chemotherapy in the treatment of juvenile cancer has been satisfactorily demonstrated by many workers within a comparatively few years. The prognosis for some children suffering from cancer has consequently been improved by the addition of this therapeutic measure to surgery and radiotherapy. It is now recognized that some of the compounds act almost specifically and solely against certain particular tumors. Since cancers are of many varieties, the search for more specific agents will continue. The ready availability of modalities—surgery, radiotherapy, and chemotherapy—to treat children with neoplastic disease imposes an increasing obligation on the parent, health officer, and clinician to utilize them and effect a reduction in the mortality rate of juvenile cancer in the United States.

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Visceral Larva Migrans With Report of a Case

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The intriguing clinical entity of visceral larva migrans was first described as such in 1952.[1] Since that time there have been numerous reports of its occurrence as a specific disease and a great deal has been learned about the pathology and the clinical manifestations. It is my hope with this paper to add a small bit to the growing knowledge of this condition and to alert the practitioner in Florida to its occurrence here. Visceral larva migrans should be of interest to the pediatrician, the general practitioner, the dermatologist, the allergist and even the general surgeon since the patient with this disease may find his way to the office of any of these.

Visceral larva migrans results from the invasion of human viscera with larvae of Toxocara canis and Toxocara cati, nematodes found ordinarily only in the dog and cat respectively. Undoubtedly many cases which have previously been diagnosed as familia eosinophilia, Löffler's syndrome, tropical eosinophilia, or benign eosinophilic leukemia were, in fact, visceral larva migrans. This condition should not be confused with cutaneous larva migrans or what is commonly called "sand worm" or "creeping eruption" in Florida. There is no relationship between the two conditions. Cutaneous larva migrans is caused by direct invasion of the skin by larvae of the dog and cat hookworm, Ancylostoma braziliense. Because of the tendency to confuse the two conditions, it would seem better to refer to visceral larva migrans as visceral toxocariasis or human toxocariasis.

Visceral larva migrans is characterized clinically by persistent but variable eosinophilic leukocytosis with total white blood cell count of from 10 to 60 thousand, and eosinophilia of from 15 to 75 per cent; hepatomegaly with or without splenomegaly is a frequent finding. The condition occurs almost exclusively in the age group from 15 months to six years and most commonly in children who eat dirt. A curious type of discrete, erythematous, pruritic skin eruption of irregular outline and confined largely to the torso is a usual finding. Irritability, insomnia and at times mental depression are seen. A chronic, nonproductive cough and associated grunting type of respiration or hiccup may be present. Hypochromic anemia is an almost constant feature of the disease.

Read before the Florida Medical Association, Eighty-Seventh Annual Meeting, Miami Beach, May 26, 1961.

Report of Case

A 22 month old, white male was admitted to the Gadsden County Hospital on Aug. 16, 1960, with a history of a chronic illness of three months' duration beginning with loss of appetite, a tendency to lessened activity, irritability, insomnia, chronic cough, and low grade fever. Approximately two months prior to admission, the mother noted a pruritic, macular, erythematous type of rash over most of the body, especially on the torso. The boy was seen as an outpatient on two occasions during the two month period prior to admission and was thought to have an acute pharyngitis with an allergic skin eruption. Roentgen examination of the chest on July 5 gave negative results despite the presence of scattered rales at the base of the right lung, and the hemoglobin estimation was reported as 60 per cent, 9 Gm. About July 20 the mother noticed worsening of the cough, which was nonproductive and hacking in type; in addition, the skin eruption became more marked and more pruritic. At approximately the same time, there was an increase in pallor with enlargement of the upper portion of the abdomen and occasional grunting respiration. An increase in irritability with periods of depression, and a daily afternoon low grade fever were present during July and early August. On August 12 the rectal temperature was 100.8 F., respirations 30, and pulse rate 120; rales were again noted at the base of the right lung; the skin and mucous membranes appeared pale, and there was marked hepatomegaly but no splenomegaly. A complete blood count revealed a hemoglobin level of 7.6 Gm., red blood cell count 3,600,000, color index 0.7, white blood cell count 40,200 with 7 per cent mature polymorphonuclear leukocytes, 24 per cent lymphocytes, and 69 per cent mature eosinophils. A first strength tuberculin test on August 13 gave negative results.

Past History.—The second of two children, the patient had been delivered normally; he had had no previous illnesses of note and none of the contagious diseases of childhood. He had received three DPT injections of ½ cc. each and two polio injections. On questioning, the mother admitted that the child had been a dirt eater for the past eight months and that her husband kept several hunting dogs in the yard.

Family History.—The mother, father and older brother were living and well. There was no family history of cancer, tuberculosis, diabetes, epilepsy or insanity.

A review of the systems gave entirely negative results except for the symptoms described in the present illness.

Physical examination revealed a temperature of 99.2 F. per rectum, pulse rate 115, respirations 30, and weight 24 pounds. The patient was a chronically ill, irritable, well developed, rather poorly nourished, 22 month old, white male. The skin was extremely pale. The conjunctivae and sclerae showed marked pallor as did the buccal and pharyngeal mucous membranes. There was a 2 plus

tonsillar hypertrophy with marked injection of the anterior pillars. Lymph nodes were palpable in both anterior and posterior cervical triangles but were considered normal. The axillary and inguinal nodes were also palpable but considered normal. The patient was slightly hyperpneic with somewhat irregular respiration; the lung fields were clear to percussion and auscultation except for a suggestion of moist, fine rales at the base of the right lung. Examination of the heart revealed the point of maximal impulse in the fourth interspace in the midclavicular line; there was a grade II, short, systolic murmur, best heard over the mitral area, which was attributed to the anemia. Examination of the abdomen revealed moderate, upper abdominal distention, but no fluid wave or shifting dullness could be elicited. The liver was palpable approximately 1½ inches below the right costal border and was moderately tender. The spleen and kidneys were not palpable. The external genitalia appeared normal; circumcision had been done in the neonatal period. The extremities were not remarkable, and neurological examination objectively was normal. A generalized, erythematous, macular, irregular rash was present over most of the torso and to a lesser extent over the lower extremities with areas that appeared to have been excoriated.

Hospital Course.—On the day of admission, routine urinalysis of a voided specimen gave negative results. The serum protein was 10.4 Gm., albumin 3.8 Gm. and globulin 6.6 Gm. per hundred cubic centimeters, giving an albumin-globulin ratio of 0.57 to 1.0. The complete blood count showed a hemoglobin level of 7 Gm., a hematocrit reading of 29 and a white blood cell count of 41,300 with 48 per cent eosinophils, 21 per cent segmented forms, 2 per cent stab forms and 29 per cent lymphocytes. The blood type was "A" Rh positive.

On admission, the child was given 500 cc. of whole, fresh blood over a 12 hour period, with a rise in the hemoglobin level to 10.85 Gm. The next day a laparotomy was performed under ether anesthesia for the purpose of liver biopsy. On entering the peritoneal cavity, a small amount of pale, serous, yellow fluid was seen, and cultured. This fluid coagulated almost immediately in the tube. The culture proved negative. The liver was enlarged and had a glistening surface on which were innumerable tiny white patches; however, on palpation, the surface of the liver was entirely smooth. A wedge-shaped specimen for biopsy was taken from the liver's edge, and the defect was closed with mattress sutures. The patient withstood the procedure well and was discharged from the hospital on the third postoperative day.

Microscopic examination of sections of the specimen showed multiple granulomata which were characterized by central fibrinoid necrosis surrounded by numerous foreign body type giant cells. Surrounding them were numerous eosinophils as well as round cells. Some of the granulomata showed fibrous tissue in the central areas while others showed a necrotic material consisting mostly of inflammatory cells. In some lesions there were irregular pieces of densely staining eosinophilic material which also stained PAS positive; no definite larvae could be distinguished as such, but it was concluded that the eosinophilic and PAS positive fragments actually represented sections of degenerating larvae. The portal areas were densely infiltrated with eosinophils as well as chronic inflammatory cells.

When the patient was last seen on Feb. 5, 1961, there were no manifestations of the disease except an eosinophilia of 36 per cent. The anemia was no longer present; the skin rash had disappeared; there was no hepatomegaly, and the appetite was good.

Discussion

Children acquire visceral larva migrans by swallowing dirt contaminated with Toxocara ova derived from dog and cat feces.[2] These ova remain viable for many months, especially in a warm climate. After ingestion, the ova hatch in the intestine into the larva form, migrate into and through the intestinal wall and while the majority of these larvae undoubtedly find their way to the liver by way of the portal circulation, some proceed directly to other organs by way of the general circulation, or by way of the lymphatic channels. It should be emphasized that diagnosis of the presence of Toxocara in the intestinal tract cannot be made by stool examination since the Toxocara cannot complete its life cycle in the human; therefore, on no occasion would one find ova of Toxocara on stool examination.[2,3]

Granulomatous lesions are produced by the larvae in the organs to which they migrate; lesions have been found in the liver, lungs, kidney, spleen, heart, eye and brain.[2-5] The lesions are variable in size, but cannot ordinarily be seen with the unaided eye except in the liver. Apparently the greater size of the granulomata in the liver is due to the tortuous tracts of the actively migrating larvae since the lesions in this organ reach lengths 20 times that of the larva itself.[6] The granuloma consists of a central area of fibrinoid necrosis surrounded by areas of epithelioid cells, many eosinophils, lymphocytes and plasma cells. Some lesions may show fibrous encapsulation and foreign body giant cells or microphages.[1,5] The larva itself cannot usually be identified in the granuloma unless serial sections are taken from one end to the other of an individual granuloma. A detailed, morphological study with reconstruction of complete larvae of Toxocara canis has been made by Nichols[7] at Tulane University. The lesions found in other organs are said to have similar structure to those in the liver except in the brain where fibrous encapsulation is more pronounced.[6] The lesions eventually heal by fibrosis. Exactly what causes the death of the larvae and the healing of the lesions is not known.

Diagnosis

The presence of chronic, unexplained eosinophilia in a child who eats dirt and who is closely associated with a dog should alert the clinician to the possibility of this disease. The presence of secondary anemia, hepatomegaly and/or splenomegaly, increased serum globulin, or the presence of the previously described skin rash should further arouse the physician's suspicion as to the likelihood of this disease. In fact, for practical purposes, the presence of marked chronic eosinophilia with one or more of the other common phy-

sical findings is perhaps enough to diagnose the disease. As yet the only certain way to establish the diagnosis is by liver biopsy. It is my belief that the liver biopsy should be done by laparotomy instead of by needle for two reasons: First, liver biopsy in a child has no more attendant danger when done by laparotomy than by use of a needle; secondly, a laparotomy allows the physician to visualize the liver surface as well as to visualize the surrounding organs.

Recently a specific hemagglutination test has been described.[8] It would appear, however, that the production of hemagglutinins may be transient; therefore, the hemagglutination test is of value only if positive.

From the standpoint of differential diagnosis, any disease which produces a rather marked eosinophilia must be considered since eosinophilia is the single feature of this disease which is always present. Included in the eosinophilic diseases are allergic disorders such as asthma, hay fever, urticaria or serum sickness, certain parasitic infestations including ascariasis, strongyloidiasis, trichinosis and pinworm infestation. The history alone would distinguish visceral larva migrans from asthma and hay fever; the occurrence of the typical skin manifestations would establish the diagnosis of urticaria; and stool examination for ova would establish the presence of pinworms, strongyloides or roundworms. One should realize, however, that the occurrence of ova of any of these on fecal examination should not preclude the consideration of visceral larva migrans as also being concurrently present, especially if the eosinophilia persists after adequate treatment of intestinal parasites.

I have seen a good many cases of children with abdominal discomfort, persistent eosinophilia and mild anemia who failed to demonstrate intestinal parasites on repeated examination. Furthermore, I have seen other children with a persistent eosinophilia and anemia as well as abdominal discomfort who continued to show these symptoms and findings despite adequate treatment for intestinal parasites which had been found on fecal examination. While these children show no other objective evidence of visceral larva migrans, perhaps some are victims of a mild visceral larva migrans infection with the persistent abdominal pain being caused by granulomatous lesions in the intestinal wall and mesentery. It should be remembered that the lesion of visceral larva migrans cannot be visualized with the unaided eye except in the liver; therefore, some of these youngsters whose disease is diagnosed as chronic appendicitis and/or pinworm appendicitis could actually be victims of visceral larva migrans involving the intestinal wall and mesentery. This is only conjecture since the clinician or pathologist would rarely have an opportunity to study microscopically the intestinal wall or mesentery.

Undoubtedly so-called Löffler's syndrome is actually a pulmonary manifestation of visceral larva migrans in many cases and is probably pulmonary ascariasis in other cases.

Treatment

There is no specific treatment. Symptomatic and supportive treatment should be used as indicated including blood transfusions or hematinics for severe anemia, and prompt treatment of any intercurrent infection. A high calorie, high protein, low fat diet is indicated. Most important is the elimination of the source of infection. Pets should be disposed of, or adequately treated and kept from contact with the infected child for a considerable length of time. In life-threatening infections, steroids may be beneficial. Hetrazan has been used, but apparently is of little or no value.[3]

The prognosis is usually good if the child is not repeatedly infected. Death rarely occurs unless vital centers of the central nervous system are invaded by the larva; however, symptoms may persist for many months and one can expect the eosinophilia to persist for at least six months to one year.

Summary

A discussion of the problem of visceral larva migrans with report of a case is presented. It is hoped that this presentation will help to alert the practicing physician in Florida to the occurrence of this disease here since a high degree of suspicion is necessary to the diagnosis.

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A Preliminary Report on the Effect of Isocarboxazid in Grand Mal Seizures

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Prominent among the signs and symptoms that must be dealt with in the populations of homes for the mentally retarded are grand mal epileptic seizures. Because of the special watchfulness and care demanded by epileptic patients, the responsible personnel of these institutions is particularly interested in any agent or method that gives promise of controlling or reducing the frequency of seizures.

The search for a genuinely effective antiepileptic has a long and for the most part disappointing history. Although modern drugs have provided the physician with the newest potential weapons for use against this disease, as late as 1956 Mautner[1] could remind us that ". . . no drug devoid of danger and reliably effective in the treatment of any type of epilepsy as yet has been found."

The effects of one of these newer classes of drugs—the amine oxidase inhibitors—have not been fully explored in this indication presumably because of the theoretical possibility of their increasing the severity of seizures. As far back as 1953, however, Reilly and his associates[2] concluded from their experiments that "iproniazid* does not lower the threshold for photic stimuli and is, therefore, probably not directly convulsant in man." One year later, Chen, Ensor and Bohner[3] discovered that reserpine lowers the threshold for electroshock and pentylenetetrazol** convulsions in mice, an effect found by Brodie, Olin, Kuntzman and Shore[4] in 1957 to coincide with a lowering of brain serotonin and norepinephrine. In 1958, Spector, Prockop, Shore and Brodie[5] noted that the brain content of these amines is increased by the administration of monoamine oxidase inhibitors.

Starting with these two facts, Prockop, Shore and Brodie[6, 7] reasoned that the latter might act as anticonvulsants. Their results showed that the drugs have a pronounced anticonvulsant effect in animals and "may warrant clinical trial."[7] Chow and Hendley[8] also "have noted anticonvulsant activity of MAOI (monoamine oxidase inhibitors) in mice against both electroshock and Metrazol . . ."

Prior to the later laboratory findings, a clinical study[9] was reported by Grisoni, Canali and Pacini at the International Meeting of Neuro-Psycho-Pharmacology held in Rome, in September 1958. The study showed that treatment with iproniazid was accompanied by a reduction in epileptic electroencephalographic patterns, attributed by the authors to accumulation of serotonin in the brain.

These observations led the medical staff of the Sunland Training Center to separate and maintain a special record of the epileptic status of a group of 50 patients who were part of an over-all evaluation (to be reported elsewhere) of the effect of isocarboxazid† on appetite, weight and general achievement in institutionalized mentally retarded patients. Isocarboxazid was employed as the amine oxidase inhibitor in the study when reports indicated that it was apparently better tolerated than the parent drug, iproniazid.[10] To our knowledge, this is the first large scale study of the effect of an iproniazid analog on the grand mal seizures of epilepsy.

Methods and Materials

Fifty patients diagnosed as epileptics were selected for special study with the amine oxidase inhibitor, isocarboxazid. All had been subject to periodic grand mal seizures for more than a year, some for their entire lives. Previous antiepileptic medication comprised practically the entire field: diphenylhydantoin sodium,* amino-glutethimide,** mephobarbital,*** methylphenyl-succinimide,# paramethadione,## phenobarbital, trimethadione,### and others. The average number of monthly grand mal seizures for each patient for the previous 12 months served as the basis for comparison with the monthly average during the period of treatment.

*Marsilid, Hoffman-La Roche Inc., Nutley, N. J.
**Metrazol, Knoll Pharmaceutical Company, Orange, N. J.

†Marplan, trademark of Hoffman-La Roche Inc., Nutley, N. J.
*Dilantin, Parke, Davis & Company, Detroit.
**Elipten, Ciba Pharmaceutical Products Inc., Summit, N. J.
***Mebaral, Winthrop Laboratories, New York.
#Milontin, Parke, Davis & Company, Detroit.
##Paradione, Abbott Laboratories, North Chicago, Ill.
###Tridione, Abbott Laboratories, North Chicago, Ill.

Isocarboxazid was administered for from five to seven months. Both initial and maintenance doses varied from 10 to 30 mg. daily, depending upon our estimate of individual requirement. In a few cases tranquilizing agents were used adjunctively when patients were previously known to be agitated or were already on such medication as a means of controlling their behavior.

The patients were constantly observed for improvement in alertness, contact with environment, appetite and behavior. Blood counts, urinalyses and liver function tests were made at the start and periodically during the trial. Weight was recorded weekly.

Results

As shown in table 1 and figure 1, there was an actual reduction in frequency of grand mal seizures in 37 of 42 patients, or 86 per cent. In eight others (seven of whom had experienced no convulsions during the previous 12 months) there was no change. In only five cases (marked with a + in table 1) was there an increase in the monthly average.

In two of the five exceptions the increase was considerable, the frequency of seizures increasing from 2.5 per month to 9.0 and 10.3, while there was an equally dramatic decrease in two, from 5.0 to 0.2 and from 7.0 to 0.4. Equally important, although not as spectacular, was the reduction to 0.0 of 17 patients who previously had experienced from 0.5 to 2.5 convulsions per month. Thus over a period of one-half year's administration of a "psychic energizer," 24 of 50 epileptic patients were completely free from seizures. This result can be clearly seen by the pattern of frequencies shown in figure 1, which also indicates the generally favorable effect of the drug on the entire group.

There was a noticeable improvement in appetite in all of the patients, along with an increase in alertness and sociability. Thirty-six, or 72 per cent, gained from one to 11 pounds, nine lost from one to five pounds, and five maintained their previous weight.

Discussion

Of all the drugs employed in the treatment of epilepsy, Mulder, Daly, Rushton and Yoss[11] recommended phenobarbital, diphenylhydantoin sodium and trimethadione as the most satisfactory, with complete control of seizures in about 50 per cent of the patients and appreciable diminution in the rest.

Table 1.—Grand Mal: Average Number of Seizures Per Month

Before Treatment	During Treatment	Change	Number of Patients	Total Change 0	+	—
0.0	0.0	0.0	7	0.0		
0.0	0.8	+0.8	1		0.8	
0.2	0.1	−0.1	1			0.1
0.3	0.0	−0.3	5			1.5
0.3	0.2	−0.1	1			0.1
0.5	0.0	−0.5	4			2.0
0.5	0.1	−0.4	1			0.4
0.5	0.2	−0.3	2			0.6
0.5	0.3	−0.2	2			0.4
0.9	0.1	−0.8	1			0.8
0.9	0.4	−0.5	1			0.5
1.0	0.0	−1.0	4			4.0
1.0	0.3	−0.7	1			0.7
1.0	0.4	−0.6	2			1.2
1.0	0.6	−0.4	1			0.4
1.0	1.0	0.0	1	0.0		
1.0	3.0	+2.0	1		2.0	
1.2	0.0	−1.2	1			1.2
2.0	0.0	−2.0	2			4.0
2.0	1.4	−0.6	1			0.6
2.0	3.7	+1.7	1		1.7	
2.5	0.0	−2.5	1			2.5
2.5	0.3	−2.2	1			2.2
2.5	0.4	−2.1	1			2.1
2.5	9.0	+6.5	1		6.5	
2.5	10.3	+7.8	1		7.8	
3.0	1.9	−1.1	1			1.1
4.7	3.4	−1.3	1			1.3
5.0	0.2	−4.8	1			4.8
7.0	0.4	−6.6	1			6.6
			50	0.0	18.8	39.1
						−18.8
		Total monthly decrease				20.3

The ketogenic diet also has been favored as the most satisfactory method of treatment, and has been discussed by many investigators, among them Wilkins[12] and Keith,[13] with the latter also including phenobarbital and diphenylhydantoin as desirable adjuvant therapy. This diet has been used for several years with varying results, but always with the drawbacks of high patient resistance, concomitant risk of nutritional deficiency and toxic ketosis. These deterrents, as well as those of certain antiepileptic drugs,[1] were singularly absent during our administration of isocarboxazid.

As to the medication's effectiveness, if the eight are omitted who were maintained at the same rate as during the year preceding the study, there was a reduction in monthly seizures in 86 per cent of the patients. If the eight are included, there was reduction or control in 90 per cent. Both figures represent a higher rate of control than the average results with the ketogenic diet reported by Talbot[14] in his classic "Treatment of Epilepsy" (71 per cent in children, 60 per cent in adults).

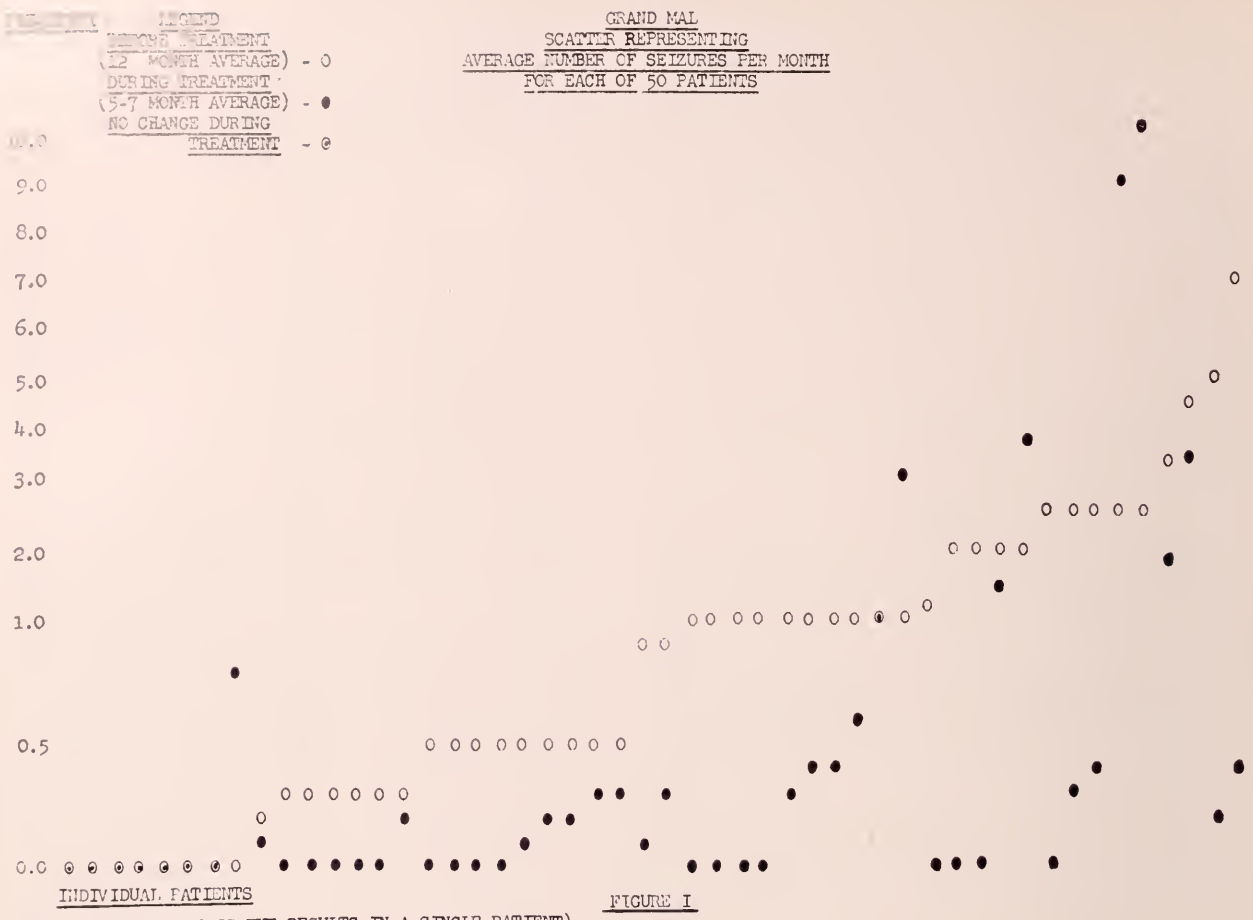


FIGURE I

Thus it may be stated that regardless of the mode and site of action of isocarboxazid, the results obtained with it in eliminating, reducing or controlling grand mal seizures in this series of epileptic patients are (a) superior to those observed with any of the entire range of antiepileptic drugs previously used by us, (b) comparable to the best reported elsewhere with various drugs.[11]

At the same time, the increased number of seizures in five patients—severe in two—seems to indicate a certain individual selectivity in the action of the drug and dictates the need for careful observation of patients under treatment. The data, however, show that any adverse effect can be quickly determined, since in four of the five (the other had an average monthly increase of only 0.8 seizures) the number of seizures increased during the first month from the previous year's monthly average of 1.0, 2.0 and 2.5 (in two) respectively to 6.0, 7.0, 6.0 and 13.0. Of all the others, one had 4.0 seizures the first month (previous average 4.7), seven had 1.0 (previous averages 0.2, 0.3, 0.5 in two and 1.0 in three), one had 2.0 (previous average 1.0) and 36 had none.

Another interesting result is the almost complete absence of aggravated hypertonia in any of these patients in whom agitation and excitement are well known concomitants. This appears to remove the basis for the prevalent reluctance to try "energizing" drugs like isocarboxazid in hypertonic patients because of their potential excessive stimulating or energizing effects.

What frequently is regarded as an undesirable side effect—increased appetite with gain in weight—must in these patients be looked upon as entirely beneficial. This property of the drug is therefore an asset rather than a drawback in mentally retarded patients who represent severe feeding problems under institutional management.

The absence of all side effects and the remarkable "pick-up" effect of the drug evidenced in improved contact with environment, increased sociability, greater alertness and clarity of consciousness also should be appreciated. Not only was there no evidence of toxicity, but the status of the patient as a whole was visibly enhanced.

Summary

Isocarboxazid, an amine oxidase inhibitor, was employed in dosages of 10 to 30 mg. daily, over a

five to seven month period, in 50 institutionalized epileptic patients who were all mentally retarded.

Compared with the monthly average of those who experienced grand mal seizures during the previous 12 months, the frequency of seizures was reduced in 86 per cent.

In seven patients who had no seizures prior to instituting therapy, none occurred during the period of drug administration.

Frequency of seizures was increased in five and considerably in only four; in these four the effect was almost immediately discernible, and therefore the drug could be promptly withdrawn if considered necessary.

All patients exhibited an increase in appetite, with a gain in weight of 72 per cent, and concomitant salutary effects: greater interest, manageability and sociability.

No side effects, including exaggeration of tension or agitation, were observed.

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Sunland Training Center.

Intestinal Obstruction Precipitated by Dicumarol-Induced Hemoperitoneum

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As the number of patients receiving long term anticoagulant therapy in the management and prophylaxis of coronary heart disease and the various thromboembolic disorders continues to increase, it behooves clinicians and surgeons to be aware of even the less common complications of such treatment. The present report cites an instance of intestinal obstruction directly related to bishydroxycoumarin (Dicumarol) poisoning, apparently precipitated by hemoperitoneum in a patient with long-standing asymptomatic intra-abdominal adhesions.

In his wide experience with anticoagulant therapy and its complications, Dr. Irving S. Wright has commented on the uniqueness of this particular sequence.[1] In nine patients manifesting intestinal obstruction due to Dicumarol poisoning whose cases have been reported previously, paralytic ileus due to diffuse serosal or intestinal hemorrhage in the wall of the small intestine either was suspected or found at laparotomy, usually with an associated hemoperitoneum and mesenteric bleeding.[2-7] The preoperative diagnosis in several instances included mesenteric thrombosis, pancreatitis and appendicitis. Other instances of hemorrhagic infarction of the small intestine with intramural hematoma as a cause for intestinal obstruction also are on record.[8,9]

Report of Case

A 54 year old housewife was seen in consultation at the Good Samaritan Hospital on Nov. 23, 1959 because of progressive shock. The patient had had long-standing hypertension. In February 1959, she had experienced an acute myocardial infarction and was hospitalized elsewhere for approximately three weeks. She was treated subsequently with Dicumarol, antihypertensive medication and mild sedation. Her prothrombin times had been maintained between 20 and 25 seconds. Approximately three weeks previously, the dose of Dicumarol was increased from 50 mg. daily (omitting every fourth day) to 50 mg. alternating with 100 mg. every other day on the basis of a prothrombin time report of 15.2 seconds. Two days prior to admission, the patient began to manifest petechiae, actual hemorrhages from the skin, and increasing lower abdominal discomfort. No bleeding was evident, however, from any of the mucous membranes. The patient also noted she had become constipated. No headaches, recent respiratory infection, recurrence of chest discomfort or dyspnea was admitted.

During the first 12 hours of hospitalization, the patient exhibited a profound drop in blood pressure—intermittent at first, but subsequently persistent and progressive. Concomitantly, increasing abdominal discomfort and distention occurred. A prothrombin time shortly after admission was greater than two minutes.

Physical examination at the first consultation revealed an extremely apprehensive and pale woman exhibiting air hunger. The pulse was 120 and faint. The blood pressure was unobtainable. There was moderate pallor of the sclerae but no icterus. No distention of the cervical veins was present. The lung fields were clear with no overt pleural friction rub. The heart was not enlarged by percussion and the sounds were distant. A grade 2 apical systolic murmur was heard, but no pericardial friction rub. Examination of the abdomen revealed a healed hypogastric hysterectomy incision with marked distention involving the entire hypogastric area. Considerable tenderness and local spasm over the left lower quadrant and left flank readily could be elicited. Discoloration of the anterior abdominal wall was not seen. The peristaltic sounds were barely audible. Examination of the skin revealed a number of petechiae, ecchymoses and hemorrhagic lesions that continued to ooze blood. There were no pathological reflexes.

An electrocardiogram taken shortly after admission demonstrated evidence of a previous anteroseptal myocardial infarction. A portable chest film failed to reveal an enlarged pericardial silhouette or significant changes in the pulmonary vascular bed. A flat abdominal film revealed marked distention of the stomach and the small bowel. The initial hemogram was as follows: hemoglobin level, 10.0 Gm. per hundred cubic centimeters; red blood cell count, 3.26 million per cubic millimeter; hematocrit reading, 33 per cent. The urine contained no blood.

The patient was treated with continuous intravenous Levophed, synthetic vitamin K_1 (Konakion, 50 mg. intravenously), Premarin Intravenous (20 mg. given twice), oxygen, parenteral fluids, and two units of fresh blood. Copious bile-tinged gastric fluid was obtained from an indwelling Levin tube over the next several days. The electrolytes were regulated with adequate fluids and electrolytes based on the previous day's performance and the blood chemistry determinations. Many attempts to reduce the flow of the Levophed were followed by a precipitous drop in blood pressure. There was still no overt bleeding from either the upper or lower end of the gastrointestinal tract; neither was there demonstrable obliteration of the psoas shadows to suggest retroperitoneal bleeding with a secondary acute ileus. Repeat electrocardiograms were suggestive of a probable acute myocardial infarction, this being accompanied clinically by a recurrence of severe angina pectoris and the development of a gallop rhythm.

The cause of the continuing ileus remained obscure. Over the next week, the patient was seen by two surgical consultants. Independently, both agreed that a partial or complete obstruction of the upper portion of the bowel was present. The possibilities entertained included bleeding into the wall of the bowel with the formation of a hematoma and ileus secondary to an acute myocardial infarction. In view of the persistent need for Levophed to maintain the blood pressure above shock levels, bleeding into the adrenals *(vide infra)* also was considered. Accordingly, she was given cortisone acetate (50 mg. every six hours intramuscularly) and was maintained on this steroid for several days. During this time, the shock abated and it was possible to discontinue the Levophed.

After an attempt to pursue a conservative program of decompression and replacement of fluid, electrolytes and calories over a period of 10 days, the patient's status degenerated precipitously. Marked confusion, athetoid movements, fever, and coarse tremors developed. These were interpreted as probably representing magnesium deficiency. Accordingly, significant amounts of magnesium sulfate were given intravenously and intramuscularly with some clinical improvement. Her condition, however, remained critical.

Both surgical consultants thought that a complete mechanical obstruction now existed. The patient was subjected to an exploratory operation on December 1. All possible precautions were taken to support the cardiovascular system and adrenal status, including digitalization and the resumption of parenteral cortisone. Several hundred milliliters of blood were encountered in the abdominal cavity as the peritoneum was opened. A high obstruction also was encountered, consisting of a loop of jejunum virtually completely obstructed in an area of chronic abdominal adhesions. A granular serositis had begun to develop. The surgical procedure was limited to freeing the bowel from these constricting bands. An extended study of the abdomen and retroperitoneal areas was not feasible in view of the patient's potentially critical status.

The postoperative course proved highly gratifying. There was progressive diminution in the amount of gastric drainage. Thereafter, she was able to reestablish gastrointestinal function without the tube and progressively to take fluids and soft solids. A superficial thrombophlebitis developed in the left thigh, but subsided with local treatment. The cardiac status continued to improve in all respects. After an additional two weeks of convalescence, the patient was discharged from the hospital on a modified postcoronary regimen.

Discussion

The magnitude of the problem of anticoagulant-induced bleeding is apparent from several reports. In one survey of anticoagulant therapy and acute myocardial infarction, 122 deaths attributable to anticoagulant therapy were reported by 64 cardiologists.[10] In another survey involving over 16,000 patients, 35 previously unreported fatalities were listed.[11] In yet another review of 227 patients managed on long term anticoagulant therapy, 70 hemorrhagic episodes were encountered in 43 patients.[12] The frequency of hemorrhagic complications from anticoagulant therapy—most of which are never reported—is also evidenced by the fact that in an experience with 107 cases of fatal poisoning over a five year period, Dicumarol unexpectedly proved to be the most common cause of death resulting from drugs taken orally.[13]

Most instances of poisoning by these drugs can be related directly to the lack of continued close follow-up of the patients, both clinically and by means of reliable prothrombin determinations. On the other hand, there is no doubt that bleeding can take place in the absence of severe hypoprothrombinemia. For example, in one recent comparative study of four prothrombinopenic anticoagulant drugs, the prothrombin activity was considered within the therapeutic range in 13 of 23 patients who evidenced bleeding.[14] In another series of 70 bleeding episodes among patients receiving anticoagulants, there were 11 bleeding episodes when the prothrombin time was recorded between 20 and 24.9 seconds, and three bleeding episodes when the prothrombin time was less than

20 seconds.[12] These experiences have been attributed variously to variations in local blood flow, capillary beds, platelets, and alterations affecting components of the coagulation mechanism other than the prothrombin concentration, namely, depression of Factor VII, Factor IX (plasma thromboplastic component, Christmas factor), Factor X, plasma thromboplastin antecedent, the Hageman factor, and the Stuart-Prower factor.[15] In both animals and man dying acutely after the administration of massive doses of Dicumarol, the histologic picture has been one of dilatation of the capillaries and of the small arteries and veins.[16,17]

Intra-abdominal bleeding has not received attention comparable to that directed to other sites of anticoagulant-induced hemorrhage (namely, cerebral, gastrointestinal from peptic ulcer and from other areas, pericardial, urinary tract, pulmonary, retroperitoneal, nasal, genital and cutaneous). In one report of 35 patients dying of anticoagulant-induced hemorrhage, intra-abdominal bleeding was listed in three instances.[11] No mention has been made, however, of an associated induced intestinal obstruction.

In the differential diagnosis of the ileus and profound peripheral vascular collapse in this particular patient, the following considerations required active deliberation: (1) unrecognized gastrointestinal hemorrhage that had not yet become manifest in the form of melena or hematemesis; (2) a hematoma involving the bowel wall, possibly following unrecognized nonpenetrating injury to the abdomen; (3) a mesenteric vascular accident; (4) reflex ileus associated with an acute myocardial infarction; (5) hemopericardium with cardiac tamponade; (6) massive retroperitoneal bleeding (the Ogilvie syndrome); (7) acute mechanical bowel obstruction on the basis of long-standing and previously asymptomatic abdominal adhesions or other intra-abdominal pathology, possibly precipitated by a hemoperitoneum; and (8) adrenal hemorrhage. Most of these disorders have been considered in detail elsewhere by me[18] and will not be further amplified.

There have been interspersed reports of intra-abdominal bleeding due to anticoagulant therapy masquerading as acute abdominal disorders.[2,19-21] Cul-de-sac aspiration has been advocated as a simple method for corroborating the diagnosis of a suspected hemoperitoneum.[2]

Bleeding into the adrenals was suspected in view of the patient's profound shock that required continuous pressor therapy and parenteral cortisone. On the other hand, the subsequent course, particularly observed at the time of laparotomy, tended to rule out this entity. This possibility deserves attention, however, in the patient with long-standing hypertension who experiences shock in the absence of clinical or electrocardiographic evidences of an acute coronary episode, a cerebral vascular accident, overt hemorrhage or infection. There are two case reports of bilateral adrenal hemorrhage culminating in a fatal "Waterhouse-Friderichsen syndrome" that were clearly associated with Dicumarol therapy.[22,23] This complication also has been observed in patients receiving heparin. The hemorrhage variously may involve the entire gland, be confined to the medulla, or take the form of scattered small hemorrhages within the gland substance. In a review of 24 patients with spontaneous adrenal hemorrhage, the striking frequency of abdominal (particularly epigastric) pain, with or without true muscle rigidity, was impressive.[24] The hemorrhage extended into the periadrenal fat tissue in six cases, intraperitoneal hemorrhage being noted in two instances.

The control of significant anticoagulant-induced hemorrhage in a patient with serious heart disease is obviously mandatory. Owing to her profound hemorrhage, anemia and shock, the patient in the case herein reported received fresh blood, a synthetic vitamin K_1 preparation intravenously, and Premarin Intravenous. There was a prompt cessation of the extensive cutaneous bleeding. By this time, however, the existing hemoperitoneum had produced sufficient peritoneal irritation to precipitate mechanical obstruction on the basis of previously asymptomatic adhesions. It is likely that this patient experienced the recurrent myocardial insult in large measure as a result of the hemorrhagic anemia.

In view of the restoration of the original risk of thrombosis and the high incidence of "rebound" thromboembolism that occurs in the second to sixth week thereafter, one hesitates to discontinue suddenly and completely drugs of the coumarin series.[25] With minor bleeding episodes, resort is usually made to temporary cessation of the anticoagulant and the administration of a small dose of vitamin K or vitamin K_1, either orally or parenterally. The author's experiences with the use of oral and intravenous estrogens, both in spontaneous bleeding and in bleeding related to dental surgery in patients receiving long term anticoagulant therapy, have been gratifying. These ex-

preferences are being reported elsewhere in detail.[26,27] The hemostatic effect of intravenous estrogen is attributable to an increase in the plasma Ac-globulin (Factor V),[28,29] a direct effect on the capillary bed involving a change of tissue mucopolysaccharides from the sol to gel state,[30] and possibly an indirect mechanism involving the adrenals.

Summary

A case of mechanical intestinal obstruction complicating Dicumarol poisoning is presented. This complication was precipitated by hemoperitoneum in a patient having previously asymptomatic abdominal adhesions. The pertinent literature, differential diagnosis and treatment are reviewed briefly.

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Conceptions: It is tempting to speculate on the results if every American physician suddenly decided to start fresh on his politico-economic conceptions. To wipe his mind clean of the predilections he has gathered. To disregard the special allegations and alarms of the missionaries of the true faith. To begin dispassionately to construct for himself a social credo built from the best available fact. Maybe he would end up with exactly the same dogmas to which he now adheres. And maybe not.—Lindsay E. Beaton, M.D., in Arizona Medicine, August 1961.

The Ablation of Rhitides by Chemical Means

A Preliminary Report

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To look young is a desire which has been ever present and a desire which is likely to remain in the minds of women (and men) forever. The plastic surgeon is faced almost daily with patients who are concerned about wrinkles of the face; however, the removal of rhitides (fine wrinkles of the face) is a problem as yet unsolved. Methods used at present include face lifting, dermabrasion, and application of certain chemicals to the skin. The latter method will be discussed here.

Certainly, the conventional face lift offers marked improvement to the aging face; however, it is limited because the entire face cannot be lifted and the hundreds of tiny wrinkles, especially those about the mouth and the corners of the eyes, remain relatively unimproved. Dermabrasion also has the drawback that the eyelids and nose do not lend themselves well to this procedure. The topical application of certain keratolytic or keratocoagulating agents offers improvement which can be achieved by no other means presently employed, and all areas of the entire face can be treated, thus leaving no obvious skin color mismatch on the face.

Both in southern California and in Florida, there are a number of "lay operators" who have set up "facial rejuvenation centers" and have used the so-called "face pealing" technique. One cannot help but be impressed with some of the favorable results which they at times achieve, but conversely, their inadequate knowledge of the toxicity of the material which they use cannot but cause more than moderate concern to intelligent persons who question their use. Certainly, a physician with some knowledge of pharmacology, toxicology, dermatology, and wound healing should be in a better position to judge the effectiveness of such a method as compared to the lay operator who has learned the technique from watching another who probably has little background himself.

With these thoughts in mind, a project was outlined and an investigation made into the clinical application of various agents to see if the desired effect could be produced. Trichloracetic acid, salicylic acid, and phenol have been used more than other agents, and phenol was used as the active ingredient in this study.

The dermatologist uses exfoliating agents as part of his everyday practice; however, the use for the purpose of covering larger areas, such as the entire face, has not been widely accepted.

Apparently small quantities of phenol can be absorbed through the skin with no serious effects. According to the studies of Deichmann[1] 77 per cent of injected phenol is excreted in the urine; about 20 per cent is destroyed by being oxidized to carbon dioxide and water, and a small amount to pyrocatechol and hydroquinone; and traces are excreted in feces.

Deichmann and Witherup[2] in their studies on phenol toxicity concluded that the extent of absorption of phenol through the skin of a rabbit appears to be determined primarily by the extent of the skin exposed and not by the concentration of the aqueous solution. In the same studies, they demonstrated that the blood phenol level showed no consistent differences regardless of whether phenol solution was 7 per cent or 75 per cent. They did observe that the 7 per cent solution caused only mild skin irritation, whereas the 75 per cent produced moderate to severe local changes. With these facts in mind, certain precautions as to surface area treated were planned insofar as the systemic toxicity was concerned, but the amount used or the concentration was not considered to be a factor.

Brown, Kaplan and Brown[3] stated that the histological explanation for the improved appearance of the skin is microscopic lamination and stratification of the collagen fibers with apparent compaction. They also stated that the change is permanent and not reversible.

Selection of Patients

All patients in this series had the background and the procedure carefully explained to them insofar as possible. All subjects had the chemical

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Fig. 1.—a. Appearance of a typical patient requesting this procedure. Note large number of tiny wrinkles in the face. b. Same patient after removal of the tiny wrinkles (rhitides) with chemical method as herein described. The loose skin of the neck was tightened by postauricular excision of the excess skin. c. Oblique pretreatment view. d. Oblique post-treatment view.

treatment carried out after tightening of the skin of the neck through a modified face-lift incision, principally by means of a postauricular approach.

Technique

The procedure is best done in the hospital with the patient well premedicated. A routine skin preparation with surgical soap and aqueous Zephiran is used. The solution is then made up fresh with the phenol concentration ranging from 50 to 90 per cent, depending on the results of a skin test which is performed several weeks in advance. The local reaction in the test area determines whether or not the phenol concentration should be increased or decreased.

A typical solution would be as follows:

Phenol	5 cc.
Distilled water	4 cc.
Croton oil	3 gtts.
Septisol	5 gtts.

This makes an approximate 50 to 55 per cent concentration. Experience in direct observation of clinical use of this solution has been the best guide as to strength, and it should be stressed that those who are interested in doing this procedure should observe the procedure in its entirity to avoid the many pitfalls which can occur. The entire face can be done with a small quantity of the solution, thus keeping the amounts of the agents used minimal.

Boric acid ointment in copious amounts is applied topically to the conjunctiva. Extreme care must be taken to avoid spilling the solution onto the surface of the eye. The solution is carefully applied to the face with ordinary cotton applicaors. Upon its contact with the skin, the patient experiences a burning sensation which subsides within a few seconds due to the local anesthetic properties of phenol. The skin then assumes a whitish color and the solution dries rapidly.

I prefer to do the forehead first, then each cheek, and then the chin and neck. By doing one area at a time and delaying about 30 minutes between applications, one has added assurance that the agents are not absorbed over a short period of time. After the forehead is complete—this includes all the forehead to just inside the hair line—waterproof adhesive tape is applied very carefully, with special effort to see that all areas are covered evenly (a small amount of vaseline in the eyebrows prevents the tape from sticking there). The tape mask is placed just inside the treated area so that when the next segment of the



Fig. 2.—a. Mask in place. Note edema of left eyelid. The nostril rims and vermilion border of the lips are not treated. b. Immediately after removal of the mask which has been on for 48 hours. Thymol iodide USP has been sprinkled on the forehead and will be applied to the entire face. Facial edema is marked. Note also the maceration of the skin and fluid that has exuded onto the surface.

face is treated, no areas will be missed. After the forehead is treated and the mask applied, with use of 30 minute time intervals, the right cheek is done, then the left cheek, the nose, and finally the chin and neck. When the tape is all on in single layers, it is reinforced with three or four more layers to insure complete waterproofness. The chemical application and mask should include the eyelids, but only to within 1/8 inch of their margins; the lips, but just short of the vermilion border; and the nose, but avoiding the alar rim and columella. If the vertical periorbital lines are deeper than average, the strength of the solution in these areas should be increased. The entire mask is then further reinforced with additional gauze squares to retain heat—a vital point for success. The patient is kept at absolute bed rest and moderately sedated for 48 hours. The diet is liquid, taken through a straw so that the mouth area is not cracked by the motion of eating. The patient should not talk and should be as quiet as possible.

Edema, especially of the eyelids, develops in 12 to 24 hours, and in some patients has been quite severe, so much so that I now treat the upper eyelids as a separate stage. Forty-eight hours following application, the patient is given morphine or Demerol, and the mask is pealed from the face. The pealing must be done very carefully. The use of cotton applicators to push the skin away from the mask is helpful. Removal of the mask is moderately painful, especially about the eyelids and neck. On removal of the mask, it will be noted that the outer layers of skin actually stick to the tape mask. There is maceration of the entire treated area and punctate hemorrhages are present. The edema is quite marked (fig. 2b) after the mask is entirely removed. Thymol iodide USP is sprinkled heavily on the face and is used when necessary thereafter to keep the surface dry. A thin eschar forms in the treated areas which spontaneously separates in five to eight days, at which time mineral oil is applied to the skin to prevent dryness. Within two weeks, regular make-



Fig. 3.—a. Pretreatment appearance of another patient. b. Appearance three months following treatment.

Note: All photographs were made by the author under identical conditions, and the negatives have not been retouched.

up can be used, and other than the erythema which remains for several weeks, there are few problems. The patient should avoid sunlight for three to six months if possible because of a tendency in some persons to pigmentation. All patients are photographed preoperatively and postoperatively.

Conclusions

1. The use of chemical keratolytic and keratocoagulation agents as a method of removing rhitides seems to have definite merit, and if properly used, these agents are useful to produce desired cosmetic effects.

2. A careful selection of patients is important, both psychologically and physiologically.

3. Extreme care must be used in applying the materials to the face.

4. Careful clinical and photographic records should be kept.

5. Those who wish to learn the technique should spend some time observing the procedure and working with a person with experience.

6. All patients should have a pretested area before undergoing treatment.

7. All patients should receive their treatment in the hospital. This is not an office or outpatient procedure.

8. The use of the technique is probably best carried out by physicians who have an understanding of the basic principles of the physiology of the skin as well as the body as a whole, rather than by lay operators who are apt to have rather large gaps in their sphere of knowledge.

Summary

The use of a chemical solution to improve the appearance of the face is discussed. The ablation of rhitides (tiny wrinkles of the face) that cannot be removed by the conventional face lift is important to the patient who wants improvement of her entire face. In all patients treated so far, the loose skin of the neck was tightened surgically. This procedure is being used in the treatment of acne scars and other types of facial blemishes, and the results will be published in a subsequent report.

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ABSTRACTS

Acute Glaucoma Following Extraocular Surgery Despite Definitive Ocular Preventive Measures. By Sherman B. Forbes, M.D. South. M. J. 53:1147-1150 (Sept.) 1960.

In the patient having glaucoma and needing an operation of a general nature, medication preparatory to general anesthesia, as well as certain postoperative factors, may present a hazard in terms of acute glaucoma. An illustrative case is presented here. It appears to be the second case to be reported in which all the criteria laid down were carried out in using scopolamine for preoperative medication in a glaucomatous patient with a resultant acute episode of the disease in both eyes. The patient had been under the supervision of the author over a number of years and prior to undergoing a hysterectomy, was known to have a chronic wide angle glaucoma associated with severe migraine and a psychopathic pattern. In spite of active preventive measures locally, including tonometric readings into the stage of surgical anesthesia, she experienced a severe acute attack of the disease on the first postoperative day. It is suggested that the pattern of glaucoma in this case may be largely explained on a neurovascular basis. The author believes that it would be well for the ophthalmologist to assume a more active role in supervising preventive measures in cases of this type. It is his responsibility to guard the patient with glaucoma from an acute attack possibly precipitated by medication incident to the operation, when undergoing extraocular surgical procedures.

"Neck-Face Syndrome" Related to Phenothiazine Drugs. By Alan S. Robinson, M.D. J. A. M. A. 173:504-506 (June 4) 1960.

Since the introduction of the phenothiazine drugs, various neurological disorders resulting

from their use have been reported in the literature. The term "neck-face syndrome" was first used by Shanon in discussing a group of patients treated with perphenazine (Trilafon) in whom dystonia involving the musculature of the face and neck developed. In this paper three cases are reported in which the patients manifesting this syndrome received different drugs of the phenothiazine group (perphenazine, thiopropazate [Dartal] and trifluoperazine [Stelazine]). Symptoms and signs described as features of the "neck-face syndrome" include protrusion, discoloration, arching and rounding of the tongue, tonic spasm of the masticatory muscles, tight feeling in the throat, slurred speech, dysphagia, puckering of the lips, oculogyric crisis, trismus, grimacing, and spastic torticollis. Two dislocations of the jaw have been reported. That these untoward reactions usually occur after administration of only a few doses of one of the phenothiazine derivatives indicates a drug idiosyncrasy rather than cumulative toxicity. This syndrome follows a benign course and usually subsides in four to 12 hours. Treatment in this series included use of a barbiturate and an antiparkinson agent, the early symptomatic relief probably resulting from the former. Noteworthy is the pronounced associated anxiety of the patients, undoubtedly due to involvement of muscle groups controlling deglutition and speech, with a resultant feeling of helplessness and impending suffocation. Although the incidence of these reactions is low, the psychological trauma associated with them should dissuade the overzealous therapist from indiscriminate use of the phenothiazine drugs.

Note: This is a very important report. It is hoped that this abstract will stimulate many physicians to read the entire paper. —Kenneth A. Morris, M.D.

Hemorrhagic Diathesis Associated with Long-Term Anticoagulant Therapy. By Paul W. Boyles, M.D. South. M. J. 53:441-446 (April) 1960.

The hemorrhagic diathesis associated with long term anticoagulant therapy in patients with "therapeutic" prothrombin times occurs with unrecognized frequency. This bleeding tendency is not related to a specific coagulation defect, but may involve multiple factors. In the investigation here reported, the coagulation defects of the blood of 35 patients with 41 episodes of bleeding associated with long term anticoagulant therapy (Dicumarol, warfarin sodium, phenprocoumon, or 2-phenyl-1, 3-indandione) were studied with similar results for the different anticoagulants. In addition, long term observations were recorded of the coagulation defects in two patients on anticoagulant therapy. In this series a multiple deficiency of factors was associated with the hemorrhagic diathesis observed in these patients. Correction of some of these coagulation defects was effected in vivo within six hours by the intravenous administration of vitamin K^1.

Polycystic Renal Disease with Renal and Splenic Artery Aneurysms. By Benedict R. Harrow and Jack A. Sloane. J. Urol. 84:447-452 (Sept.) 1960.

Polycystic disease of the kidneys is a congenital and hereditary disease associated with many varied anomalies. In adults it is frequently associated with cerebral aneurysm along with liver and pancreatic cysts. These hereditary anomalies may be transmitted by a dominant, autosomal gene. In the case here reported the renal and splenic artery aneurysms were probably coincidental. Problems in the management of this case as well as the use of translumbar aortography and the incidence of renal and splenic aneurysms are discussed. Aortography should be used to diagnose calcified rings, the authors conclude, if surgical measures are anticipated.

The Thimble Hook. By D. Ralph Millard, Jr., M.D., F.A.C.S. Plast. & Reconstruct. Surg. 26:555-557 (Nov.) 1960.

The emphasis in modern surgery has shifted from speed to gentleness, this author points out, and the epitome of this atraumatic technique is practiced by the plastic surgeon. It is he who has stressed the value of the hook, pointing out that its prick is less traumatic to tissue than the crushing clamp of a forceps. For surgeons who already favor the hook, he suggests that they may find most useful the thumb and finger thimble variety which he describes. A thimble mashed oval with its top cut off forms a ring which can be fitted to a gloved thumb or fingertip. If the dorsum of the ring thimble is divided, a spring clasp is formed which renders the fit even more adaptable. Short fine hooks can be soldered to the metal thimble ring in positions most efficient for everting wound edges and lightly lifting tissue. This instrument can be made by any physician with the aid of a dental technician or the Storz Instrument Company can make it upon request.

President's Page

It Is Worth It!

Not long ago a rather intelligent woman patient asked me this question: "Doctor, why is it that the medical profession has to fight for its very existence?" My first impulse was to deny the implications in this question. On second thought, I realized that with all the propaganda being put forth in the various news mediums attacking the medical profession in one way or another, the average layman was seeing only one side and could not fully understand my position if I denied it. Undoubtedly there have been more and more attacks on the medical profession, chiefly aimed at the American Medical Association, in the past few years. A good example is what happened in the House Ways and Means Committee in the recent hearing on HR-4222, the King-Anderson Bill. Most of the supporters of this bill, as so ably pointed out by our own Dr. Ed Annis, were attacking the American Medical Association rather than pointing out any features of the King-Anderson Bill.

Why has this condition come to pass? Frankly, I admit that I am not able to answer this question completely. There are, however, several factors to be considered.

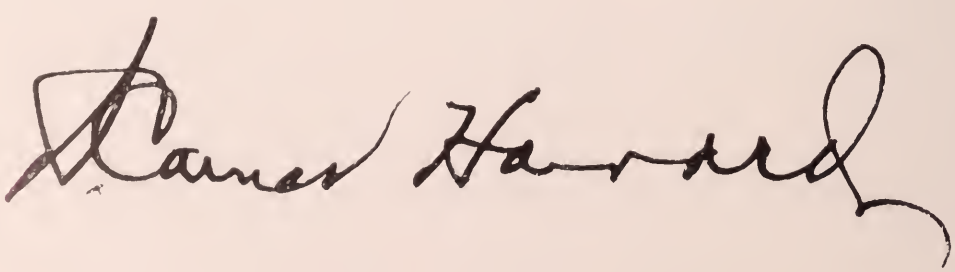
1. We all realize that there is a trend toward a socialistic state which cannot be attained without first conquering medicine. The medical profession as a whole is against socialized medicine, and those favoring socialism are going to try to beat us down regardless of what tactics they have to use to do it.

2. Medicine as a whole has taken the defensive attitude and until recently has seldom been recognized as taking the offensive although there are many instances through the years where it has. Most of us practicing medicine have been too busy doing what we were trained to do to take cognizance of the fact that our birthright as doctors is being taken away from us. Not even our worst enemies can say that we have not done a good job practicing medicine in the United States.

3. Some in our profession have been too complacent and lackadaisical to care what was happening. There are some who are defeatists. I hope that these few are seeing the handwriting on the wall and will join with organized medicine in helping to defend American medicine and put our antagonists on the run.

4. I regret to say that in our profession there are men who are arrogant and greedy, and who do not care for their profession and what it stands for but only for themselves. These men are *few,* I am glad to say, but it takes only one rotten apple to spoil a barrel. They should be culled out.

It is a peculiar thing that doctors individually are greatly loved and honored by their patients, but collectively, such as the American Medical Association, the public as a whole is suspicious of them. I think here we have the key to solving this particular problem. Each doctor must do all in his power to sell the medical profession to his patients, not in a boasting way but simply by trying to point out what medicine has done, what it is doing, and what it plans to do.



Thanksgiving—again

Thanksgiving should be a time of introspection, when we consciously are grateful for the blessings we take for granted the rest of the year. How many of us have given thanks for being members of a profession which occupies itself with the needs of other men? Giving of ourselves, relieving pain or anxiety in others, is so much a part of our life as physicians that gratitude for the opportunity is often smothered in resentment at interruption of family plans or overconcern with the business side of practice.

"Now, if I carry out this oath and break it not, may I gain forever reputation among all men for my life and for my art. . . ." So ends the Jones translation of the Hippocratic Oath. It lends emphasis, not given by other translations, to the fact that each practitioner's reputation reflects directly upon the entire profession. In recent years this has been brought forcibly home to the medical profession by innumerable articles and analyses by the capable and incapable which report a drastic tarnishing of the doctor's "image," presumably based on dissatisfaction by the public with a few physicians and projected to include all physicians.

Isolated instances of mistreatment, nontreatment, or overcharging of older folks have been used by some to support federal control of the care of all oldsters. Fortunately, this control was not established by the 1961 Congress, but the issue is not dead. The following editorial, reprinted with permission from the Wall Street Journal, is worth reading and re-reading, for it highlights the tragic change which has taken place in the concept of charity. It does not place the blame at any door, but each of us might well question our own part in causing this transformation.

J. M. P.

Charity Is a Dirty Word

In the days of our childhood there were three things to abide in men forever, and the greatest of these was charity.

For charity, in those days, meant a divine love for man, the benevolence of all men of good will toward their brothers. It was kind. It envied not. It vaunted not itself. It was not puffed up. It was not gained simply by bestowing all one's goods to feed the poor, because it was a thing of the heart without which man was nothing.

So it was a word such men as Thomas Jefferson would use with dignity, deeming it the duty of each man by himself and all men joined together to show it toward their neighbors. It was an honorable word with which to bespeak the responsibility of the whole community for those among it who were old, sick or otherwise unfortunate.

But not any longer. First the word itself lost its meaning, and those who would translate the message of St. Paul were constrained to speak only of love, a word of so many meanings as to have no meaning at all.

And now, finally, charity has become a dirty word. In newspaper advertisements all across the land, paid from the rich coffers of the AFL-CIO, the word is spat out: Is medical care to be available for the needy as a handout—as public charity? It is a word from which good men shy as they arise to speak on the floor of the United States Senate.

There they have been speaking about a simple objective, to see that no old person goes without proper medical care because he lacks the means to provide it for himself. The question is, how?

Now this problem, be it noted, is only how to care for a small minority; among the blessings Providence has bestowed on this country is that those among us who are needy are the few, not the many. So it would not be too costly or too difficult to set up a system—even one run by the Federal Government, if that is insisted upon—under which those in need might have a formal and orderly way to receive aid from the whole community.

But to set a standard of need, we are told, would be public charity, and charity is an evil thing. It demeans a man to have to state that he is in need. So to care for this minority some people tell us we must put the medical care of every old person, fortunate and unfortunate alike, in the hands of the Federal Government.

Well, it's true that men of pride and dignity do not welcome a situation in which they must turn to others for succor. Indeed, it is the desire not to be "beholden" that makes free men labor and save to provide for themselves and their own. But surely it is not "demeaning" for a man struck down by what he cannot help to be helped by his fellow human beings. There is no shame for the blind in being led by those who can see.

What is truly demeaning is for the hale man, the free and self-reliant man, to be beholden to the Federal Government for his food or his shelter or his care in sickness. For then he lives not by the charity of his fellow men in his distress but simply by taking from them. It is thus that men of good will are shamed.

Yet that is precisely what is proposed by those who treat charity as a dirty word. If all they really sought were succor for the unfortunate, charity would provide it. What they really seek is not succor for the needy, but a way to put all men upon the same level. If they can achieve a system where the Government provides all men with their needs, then no man shall have more than another. We will all, in time, take what Government provides.

We do not know the word for this new spirit. But whatever it is, it has no kindness. It rests on envy and it vaunts itself, puffed up in the belief that it can do for all men better than all men can do for themselves. It is the same spirit that already walks across wide areas of the world, where men are but numbers to be fed, clothed and nursed for other purposes than humanity. Whatever it calls itself, it is not a thing of the heart.

And we are so old-fashioned as to wonder, if charity is to be lost to this new spirit, then how long there will abide faith in every man's dignity and the hope that here we will preserve it?

Reprinted from
The Wall Street Journal
August 24, 1960
"Review and Outlook"

Visceral Larva Migrans

The case report on "Visceral Larva Migrans" by Dr. Hilliard R. Reddick in the current issue of The Journal is timely. He directs attention to a disease, the recognition of which might easily be missed unless the clinician has a high index of suspicion and is aware of its variable manifestations.

As long ago as 1952, Beaver[1] reported three cases of youngsters in New Orleans who had hepatomegaly, anemia and marked eosinophilia, and who had a history of eating dirt. On laparotomy, the livers were found to have eosinophilic granulomata, some of which contained living larvae of the dog roundworm (Toxocara canis). Snyder,[2] as recently as July 1961, summarized the records of 20 children over a 10 year period at the Ochsner Clinic, in whom the clinical diagnosis of visceral larva migrans had been made. In 10 of these the diagnosis was proved by liver biopsy. During the interim between these reports occasional contributions to the literature have emphasized the occurrence of the disease and the possibility of severe complications.[3-6] The two articles mentioned emerged from experiences in Louisiana, but do not imply that the disease is restricted to that area. Dr. Reddick points out that it can, and does, happen here.

It is generally agreed by investigators that the etiologic factor is the ingested ova of the canine roundworm (Toxocara canis) which cannot complete its usual life cycle in the human host. Symptoms apparently are caused by larval invasion of the liver, producing hepatomegaly with significant eosinophilia and often anemia. Almost invariably the victim has been a young child who eats dirt. Subsequent complications may occur from invasion of other tissues, especially the eye. These lesions, actually intraocular granulomata but resembling retinoblastoma, have sometimes led to unncessary enucleation of the eye.[4]

Unfortunately, there is at this time no accurate confirmation of diagnosis except by liver biopsy. To use the language of the bridge player, "a peep is more valuable than a finesse." Visual inspection of the liver and the opportunity to obtain adequate biopsy material would seem to make the surgical approach more practical than the use of needle puncture. Perhaps, later, pre-

cipitin tests or isohemagglutinin titers may be of value, although results to date have been disappointing.[5]

It is interesting that therapy consists primarily of symptomatic measures, other than the alliterative admonition: prevention of pica. Snyder[2] seemed favorably impressed with the use of diethylcarbamazine (Hetrazan). Pike[6] last year (1960), after use of several drugs in experimentally produced visceral larva migrans in mice, concluded that some of the failures of Hetrazan therapy in human cases may be due to inadequate dosage.

Perhaps we have overlooked visceral larva migrans as a diagnostic possibility in some instances where persistent eosinophilia with hepatomegaly occurred in a small child. The situation must be ruled out on an individual basis. But, in the absence of a clear-cut clinical picture or a specific diagnostic test other than biopsy, we must guard against using the disease as a diagnostic dumping ground. Dr. Reddick is to be congratulated for his excellent presentation of an unusual problem.

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Warren W. Quillian, M.D.
Coral Gables

New Responsibilities of the State Board of Medical Examiners of Florida

It is the duty of the State Board of Medical Examiners of Florida to license, by examination, qualified medical doctors and to police medical doctors who have been granted a license. The amendments to the Medical Practice Act, which were passed at the 1961 session of the legislature, will facilitate these duties.

In order that applicants may be better qualified for the examination, it is now necessary that a year of approved internship be completed. Most states already had this requirement. Since the doctor is not prepared to practice immediately following his graduation from medical school, it was believed that at least one year of approved internship should be required before the applicant is permitted to take the examination for a license to practice in Florida. Five years in private practice may be substituted for the one year internship.

The amendment affecting most members of the profession is the requirement that an annual registration fee of $10 be paid to the State Board of Medical Examiners. This is in addition to the registration fee of $1 which is paid to the Florida State Board of Health. The fee will be used by the Board to carry out its disciplinary duties since investigators and additional office personnel, as well as hearings, will be required to perform these responsibilities. The Committee on Membership and Discipline of the Florida Medical Association will be utilized by the Board to assist in obtaining information concerning a member of the Association.

Physicians must register with the State Board of Medical Examiners on or before Jan. 1, 1962, and each January 1 thereafter. Failure to do so will result in immediate suspension of license and a penalty of $10.

The Medical Practice Act does not apply to physicians practicing in state institutions and to interns and residents pursuing accredited training. House physicians not in approved training cannot practice in a hospital in this state without special consent from the State Board of Medical Examiners.

Much has been said concerning the need for more adequate disciplining of the members of the medical profession. Insinuations have been made indicating that if it is not done within the profession, it will be done by those outside the profession. It is certain that medical doctors are better equipped to perform this duty than any other

person, group or profession. The task falls upon the State Board of Medical Examiners and the Florida Medical Association and will require the cooperation of all. It is hoped that the offenders are not many, but a small number can create an atmosphere of lack of confidence and doubt around the entire profession. To protect the many against the few, it is necessary to smoke the offenders out and turn the spotlight of truth upon them.

HOMER L. PEARSON JR., M.D.
SECRETARY-TREASURER
STATE BOARD OF MEDICAL EXAMINERS
OF FLORIDA
MIAMI

Refugee Physician Problems

During the last year almost 80,000 Cuban exiles have entered the United States in their flight from Communism. The majority of them have settled in Florida, particularly the southeastern part of the state. Among these emigrees are over 500 physicians, many of whom were in private practice.

Two principal problems confront these colleagues. The first problem is subsistence inasmuch as all of them have left their belongings and savings behind. The second problem is that these physicians are unable to support themselves by using their professional skills. The unfortunate circumstance thus arises that in the presence of a nationwide shortage of interns, residence and rural practitioners, a large pool of skilled and practiced talent lies fallow.

Naturally this country wishes foreign physicians to be able to meet the same requirements which we demand of ourselves. The foreign graduate is therefore asked to meet two standards: the national qualifying examination (ECFMG) and the requirements of the individual states. The ECFMG examination requires a broad general knowledge of medicine, and the states usually insist upon citizenship prior to licensure for a position other than on a house staff.

In view of the fact that 85 per cent of the refugees have been in a specialty, the ECFMG presents a significant challenge, and since subsistence needs are immediate and charity is not desired, it is an additional obstacle to ask the needy but experienced practitioner to meet the state requirements by serving a second internship or residency while waiting out the domiciliary period.

The University of Miami has developed a broad intensive bilingual review course in Medicine, with concomitant courses in the English language. This course serves to shorten the preparatory time needed to pass the ECFMG. The domiciliary requirement remains unsolved. The majority of exiled physicians have indicated their desire to remain in this country as citizens. They have taken places as interns and residents and are applying for citizenship. A fortunate few have acquired appropriate employment as consultants in federal posts and on university faculties. The time may be ripe at this moment for our states to liberalize their laws and help solve *our* twofold problem: the need for physicians in many areas and the problem of resettlement of the physicians who are capable of passing our examinations.

EMIL P. TAXAY, M.D.
MIAMI

The Loyal Opposition

"The good news of God's redeeming love and saving power, declared in the teaching of Jesus Christ, was proclaimed in His concern for suffering and His ministry of healing." With these words invoking the advocacy of Divine Power, the General Board of the National Council of Churches, on Feb. 22, 1961 proceeded to adopt a resolution, including this quotation, calling for the federal government to institute a medical care program for the aged under the Social Security system. This resolution was passed after study, testimony, and research, none of which included any consultation with the American Medical Association.

As of May 10, 1961, the National Council of Churches had received a paltry 20 letters from physicians disapproving this action by the church group.

A mimeographed letter to these dissenting physicians from the Reverend William Villuame, Executive Director of the National Council, is quite illuminating. For the most part, it is the old rehash of the responsibility of the churches to speak out on all issues, be they social, political

or economic—for all of these realms of human relations must have an ethical and moral component.

The Reverend Mr. Villuame would have us all believe that the church is the final authority on all ethics and morality in human relations. In justifying the Council's official statements, he points out that this body is a "representative assembly." It is made up of elected representatives of the 33 member churches and their 40 million members. The crux of the matter as to whom they represent is summarized: "The pronouncements, resolutions, and other actions of a General Assembly have precisely the status and weight of being actions of such a *representative assembly;* no more, no less. They will be useful as a guide to churches and to their members and to the nation and the world in finding God's will, and doing it." This little tickler succeeds in placing Social Security medical care in the realm of God's will. The statement as a whole clearly indicates that the National Council truly represents no church member—it serves only as a church-supported research, administrative, and propaganda device for economic, political and social action. The Reverend Mr. Villuame further quotes the General Assembly as stating, "The National Council has no authority over its churches or members; but never the less has a right to expect from them either loyal support or loyal opposition. . . ."

Those physicians who are vitally concerned about the Social Security approach know this is the giant step necessary for socialization of medical care in the United States. The socializers, including Reuther and the Socialist Party, applaud this step as the opening wedge. The National Council of Churches and other religious organizations are driving the wedge with all the resources at their command.

The National Council has made pronouncements on other matters: for recognition of Red China, against right to work laws, against the Bricker Amendment, against the Connally reservation on the World Court, and for the ascendancy of the United Nations over the United States. This is not a very pretty record from the conservative viewpoint, which espouses personal freedom as human freedom.

Dissent is stirring, not in the form of loyal opposition. A small Methodist church in Mississippi has withdrawn recognition and financial support of the Council. A Methodist church in Texas has done the same. A high Episcopal official in the West flatly states that the time has come to consider withdrawing the entire Episcopal Church from the Council. Another young Episcopal minister said from the pulpit: "But the Council ought not to do what it is doing; coming out flat-footed for this or that side of some vexing and complicated political or economic problem, giving the impression this is the Christian point of view! Who can say what is the Christian point of view in such questions? Some Christians are socialists, some are monarchists." His parishioners supported his beliefs by further stating that the church should make moral judgments, but not pretend to political wisdom.

Physicians should and must educate themselves about the enemies of medical care under the free enterprise system. They should be in the forefront of activities to influence intelligently individual and group thought and action in relation to political medicine. When necessary, as in the case of the National Council of Churches, we must question the validity of its existence.

Harlan W. Johnston, M.D.
Jacksonville

OTHERS ARE SAYING

Reflections on the Image of American Medicine

Anyone who reads the slick prints today must have observed that every occupational group or institution is intensely preoccupied with its "image." Indeed, to speculate about one's image has become a contemporary obsession, in somewhat the same way that the self-examination of one's complexes and aggressions or the contemplation of one's navel has obsessed people at various times in the past.

This agonizing solicitude about our public images testifies to the grotesque effect of the public relations philosophy on our present-day values and motivations. For ours is a society so bemused with manufactured symbols and vested illusions that most of us are more concerned with manipulating our images than with becoming what we want people to think we are.

The medical profession, like every other group, has two images and back of both images, a reality. Our *interior* image is the picture we fondly indulge of ourselves, the picture we would dearly

love to project on the public screen. Our *exterior* image, of course, is the picture we actually do register in the popular mind. Neither image, as a rule, exactly coincides with the reality of ourselves. But if either or both images depart too radically from actuality, we are likely to be in deep trouble.

Just as there are some physicians who treat the symptom rather than the disease, so there are some public relations practitioners who try to manipulate the image instead of improving the reality. A candid examination of one's popular image should suggest diagnosis and treatment of the subject, with assurance that a shinier reality will project a happier image.

Radio and television, some powerful labor unions, the natural gas industry, and most recently the pharmaceutical manufacturers all provide eloquent examples of what can happen to a powerful group when its social image is sullied by revelation of questionable realities.

The exterior images of personalities or groups in our frenetic society may be downgraded at varying speeds and by any one or a combination of causes, but the basic and inescapable fault is almost always a deep and elemental failure to match real performance with vaunted ideals.

What can we say of American medicine's popular image in 1960?

It is perhaps both a major strength and a dangerous liability to the medical profession that the nature of its mission and the purity of its aspirations have combined to produce, historically, an image of great nobility. The traditional picture of the physician is that of a learned and sacrificial man, who works all hours of the day and night, whose "prime object . . . is . . . service to humanity," and for whom "reward or financial gain is a subordinate consideration." But this ideal physician is an anachronism in an age in which the rest of us work feverishly (but only five days a week and from nine to five) in unabashed pursuit of the "quick buck"; and in a society where power, glamour and conspicuous consumption seem to make a mockery of humility, modesty, and the life of service.

To trace the myriad convoluted trends and circumstances that have altered and in my opinion tarnished the popular image of the modern physician would require at least a volume.

In this limited space, we will consider only one element, but, I think, a central one, in the deterioration of that image. I refer to the factor of remoteness, of the lack of personal involvement between patient and doctor. Compared to the emotional content of the doctor-patient relationship fifty years ago, one might almost characterize that relationship in our day as an estrangement.

Part of the price we have paid for the scientific benefits of specialization has been to separate physicians from one another and to circumscribe the interest and concern of each physician both with respect to the people as a whole and with regard to any one patient.

Science has given physicians so many instruments to test and treat disease, and the doctor's understanding of disease itself has so far outpaced his understanding of the patient, that the personality of the physician has gone into partial eclipse along with the art of medicine. Indeed, it seems that many people today respect and admire the apparatus and institutions of medicine more than they do the physicians who alone can give them any function.

All this is profoundly regrettable in what we all recognize as an age of insecurity, in which the truest definition of an optimist is one who thinks the future is uncertain.

The estrangement of medicine from modern society is remarkable in the political and social arena, too. With its intense inherent attachment to the principle of individual responsibility, and its insistence on the individual patient, rather than society, as the proper object of rehabilitation, medicine again finds itself somewhat out of touch with the dominant social philosophies of our times.

Thus there are radical differences between the ideals of the individual physician and those of his fellow workers in our affluent society, and there is also a radical conflict between the profession's social outlook and the popular ideologies of our day.

These conflicts pose some extraordinarily difficult problems from a public relations viewpoint. For it is one of the easiest tricks in the trade to portray the individual physician's attachment to individualism as blind selfishness, ignorant reactionism, and antisocial obstructionism.

We must all be realistic enough to admit that organized medicine's activities in the socioeconomic realm have not always been utterly devoid of crass self-interest. Medicine has been far too slow in recognizing the fact that modern medical care is now so highly respected and so universally

coveted that it has become a basic human right, along with liberty, breathing, and the right to have a TV set. American medicine in the 1960's will undoubtedly confront some crucial issues, in which the man in the street will make the ultimate decisions. Whether or not he harkens to the voice of medicine, urging him to leave intact the basic freedoms under which physicians can continue to progress in scientific skill and can practice the art of healing for the direct and exclusive benefit of the patient—all this will depend on the image of the physician and of the profession as a whole that rests in the mind and heart of the average American citizen.

The image of the physician will be shaped and colored by his daily performance, by the qualities of dedication and consideration he displays in his daily rounds.

And it would appear that the average citizen's image of American medicine as a whole can be vastly enhanced not by any radical change of social policy, but by a better exposition of policy, and by a more skillful and imaginative public interpretation of the ideals and principles which have enabled American medicine to reach its present high level of effective service to ailing humanity.—J. E. B.

New York State J. Med.
60:3216-3217 (Oct. 15) 1960.

AIDS TO PRACTICE

Question: My secretary uses the standard bookkeeping system on patients' accounts—the day book and individual ledger cards. She usually itemizes on the professional size statement form, and uses window envelopes. Recently she has had to work after the usual hours to get out the end-of-month bills. I am not ready for a radical change of routine or the purchase of a fancy system or machine. Is there anything you can suggest to save time in this work?

Answer: Continuous form statements can save considerable time over individual statements which must be individually inserted and aligned. These cannot be produced by the average job printer, but are available from several large printing companies. Only one, however, to our knowledge, offers continuous form statements in lots small enough and at prices reasonable enough to be practical to the profession. Purchases in lots of 2,000 to 10,000 statements, at modest cost, can be made from the Debisteve Company, 713 S. Tenth St., Minneapolis 4, Minn. The panel would be interested in knowing of any other sources competitive to Debisteve.

Cycle billing is another device for reducing the peak load of month-end billing. The alphabet may be divided, for example, into five parts containing approximately the same number of patients' accounts. One-fifth of the billing process is done, then, on each of five days rather than the entire job on one day. By planning ahead, the process would be started in time to release the last bill in time to have it delivered to the patient by the first of the month.

Question: What is new on the Florida Professional Corporation?

Answer: There may be much going on of which the panel is not informed. This is a matter for close liaison with your attorney. We hear that the position of the Florida law has been strengthened by recent rulings of the Attorney General of Florida to the effect (1) that the special type professional corporation may revert to the ordinary type Florida corporation upon the death of the physician, thus allowing a corporate life beyond that of the natural individual, and (2) the professional corporation may be organized with only one officer and one director. On the other hand, the Internal Revenue Commissioner in Washington has passed down the word that probably it will be near the end of 1961 before a ruling on the Florida law may be expected. There are

Questions and comments on appropriate economic and practice management problems are invited for publication in this column. Answers to your questions will be provided by a panel composed of various Florida members of the Medical-Dental-Hospital Bureaus of America.

two distinct schools of thought on this matter. One says, "Do it now, for tomorrow may be too late," and the other follows the conservative view, "Let the other guy stick out his neck; I'll do it later if it proves safe."

Question: Why can out-of-town collection agencies offer 10 per cent rates when local bureaus charge 33 per cent to 50 per cent of amounts collected?

Answer: Any collection bureau can make a profit at a 10 per cent rate by "creaming the accounts." In fact, any out-of-town agency is limited to generally ineffective correspondence approaches which are a small part of the tools of the local bureau. The 10 per cent collector cannot afford to do an effective tracing job, must select those accounts which appear easy to collect and leave the rest with a superficial mail contact. This is borne out by the fact that among the established specialized collectors across the nation it costs in excess of 35 cents to collect each dollar. This estimate does not take into consideration the adverse character of Florida laws affecting collection of just debts, and the very large number of "skip" accounts referred to local bureaus in the tourist sections of the state; your local bureau could have a considerably higher cost ratio.

The amount of recovery and the character of the collection process are more important than the collection rate. No ill will or grievances should result from the collector's actions; rather, his approach includes clarification of misunderstandings and full consideration of the circumstances of each case, if he is the man you should use. Given your full cooperation and sufficient time, your local bureau can recover several times the amount from your "salvage" accounts ordinarily achieved by the nonresident collector.

CLINICAL COMMENT

Scientific Session

Florida Society of Anesthesiologists

The annual scientific session of the Florida Society of Anesthesiologists was held September 16-17 at The Carousel in Daytona Beach. Speakers included Dr. David A. Davis, Professor of Anesthesiology, University of North Carolina School of Medicine, Chapel Hill, N. C., who discussed "The Question of Operating Room Monitoring," and Dr. T. W. Andersen, Assistant Professor in Anesthesiology, Department of Surgery, University of Florida College of Medicine, Gainesville, whose subject was "The Effect of Anesthesia on the Response to Vasopressors in Man."

Dr. Davis prefaced his remarks by stating that there is and should be no substitute for the diligent use of "the eyeball, the finger, and the ear" as monitoring devices. Electronic monitoring devices should be used in addition to these primary devices, never instead of them.

The purpose of electronic monitoring should be instantaneous recording and measuring of any physiological process of interest to the anesthesiologist. "The device should be simple and easily used by anyone in any operating room at any time. It is recognized that today's monitoring equipment is not satisfactory and is far too complicated for the average physician to use."

Electrical engineering of today's caliber can provide monitoring devices for almost any conceivable physiologic process. There is, however, a severe problem of engineer-physician liaison. The engineers have little knowledge of medical problems, and physicians seldom understand what is available in the engineering field. Further, expert anesthesiologists cannot agree among themselves on what is needed—even what is the single most important item to be monitored.

The following are some of the more common modalities being monitored in today's operating rooms: (1) The electrocardiograph furnishes data from which one can note changes in the

Under this heading, The Journal presents information gathered by Florida physicians attending the various medical meetings. The thoughts expressed are those reported by the author and are not intended as scientific references.

heart rate, the presence of ectopic and premature beats, the loss of P-waves, S-T depression, and so forth. All of these are signs of abnormality in the patient's homeostasis. (2) Pressures, both intra-arterial and intravenous, during surgery and in the postoperative period are easily monitored. There is in development an apparatus for measuring blood flow in an artery or an organ without the introduction of intra-arterial materials or catheterization of the artery itself. Such apparatus is not available for common usage at the present time. Evidence from data collected from such monitors indicates that blood pressure is not necessarily related to blood flow. (3) Ventilation can be monitored in various ways. The ideal method should be monitoring of the end result of ventilation, namely, oxygen and carbon dioxide tensions in the tissues themselves, as in the heart and brain. This now is possible also.

Dr. Davis in conclusion attempted to summarize this subject by answering the question: "Why use operating room monitoring devices?" He stated that since virtually all patients at North Carolina Memorial Hospital are studied with electronic monitoring devices, many of them exhibit unexpected and unanticipated abnormalities in homeostasis. Further, Dr. Davis stated that since widespread monitoring has been instituted, there has been a general improvement in patients' operative and postoperative condition. He attributed this improvement to more careful and watchful administration of the anesthetic, brought about by correction or attempted correction of many subclinical abnormalities discovered via the monitoring devices.

Dr. Andersen, in discussing anesthesia's effect on the response to vasopressors in man, stated that everyone in anesthesia indulges in polypharmacy to some extent. The object of this beginning study is to seek unknown, unnoticed, or unwanted side effects due to any two or three of these combinations of drugs. The vasopressor chosen for this study was Wyamine. The "other drugs" for the interaction study were various anesthetic agents.

The experiment was set up as follows: Patients with normal cardiovascular systems were selected. They were divided into two groups, namely, those anesthetized with cyclopropane and those anesthetized with intravenous nitrous oxide. In each group identical dosages of Wyamine were administered, based on the patient's weight. Blood pressure, pulse, and other processes were monitored. In each group three doses of increasing amounts of Wyamine were administered, monitoring the results following each dose until a stable blood pressure plateau was reached. Then these patients were lightly anesthetized according to their group, and again these modalities were carefully monitored. After stabilizing, three identical dosages of Wyamine were again administered as previously and these results recorded.

Results and Summary.—Wyamine, according to the literature, is a drug possessing primary cardiac action and little peripheral action. These results seem to refute this. Based on records from monitored data and calculations of cardiac output, Wyamine was found to have little effect on cardiac output directly (it certainly does not increase cardiac output). The main effect of Wyamine is peripheral vasoconstriction. Blood pressure responses to Wyamine after anesthesia could not be predicted by known responses to either agent given alone. There was definitely a synergistic response or interaction noted in both groups of patients. In one patient delayed atrioventricular conduction occurred (Wenckebach phenomenon), which disappeared on discontinuance of the anesthetic agent.

Certainly, everything is not known about the inner action of these drugs. The anesthesiologist should be alert and on the lookout constantly for unwanted and unknown responses to combinations of anesthetic and ancillary drugs.

John W. Caffey Jr., M.D.
Jacksonville

Committee on Scientific Work Issues Last Call for Papers For Annual Meeting Program

The Committee on Scientific Work of the Florida Medical Association has announced that the deadline for submission of papers for consideration for the program of the Annual Meeting is November 20. Physicians desiring a place on the program should submit to the Committee an abstract of not more than 50 words, or the complete paper.

The Scientific Exhibit, being confined to presentations by physicians only at the 1962 meeting, should be of particular interest. The Committee at its meeting in early December will consider short descriptions of proposed exhibits. Physicians should submit a description prior to November 20.

NEWS-PERSONALS

Dr. S. Carnes Harvard of Brooksville, President of the Florida Medical Association, attended the meeting of the Gulf Coast Clinical Society held October 14 at Pensacola.

Dr. Thomas S. Edwards of Jacksonville presented a paper before the Section on Ophthalmology and Otolaryngology at the 55th annual meeting of the Southren Medical Association held at Dallas on November 6-9.

Dr. Sherman B. Forbes of Tampa presented an instructional course on cyclodiathermy at the annual meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago in October.

Dr. George T. Harrell of Gainesville, Dean of the University of Florida College of Medicine, was principal speaker at the September 25 meeting of the Meninak Club of Jacksonville. Dr. Harrell's topic was medical education.

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Florida Medical Assoication, was guest speaker at a recent meeting of the Southside Kiwanis Club of Jacksonville. Dr. Day discussed "Local Responsibility."

The December 9 Post Graduate Cardiac Surgical Colloquia presented by the Section of Thoracic and Cardiovascular Surgery of the University of Miami School of Medicine will be conducted by Dr. C. Walton Lillehei, Professor of Surgery, University of Minnesota School of Medicine. The subject is "Surgical Consideration in the Repair of Ventricular Septal Defect with Pulmonary Hypertension." The Colloquia is one in a series being presented by the School of Medicine at Jackson Memorial Hospital.

Drs. Clifford C. Snyder and Robert A. Nelson Jr. of Miami and Dr. William F. Enneking of Gainesville participated in the Symposium on Immunologic Disorders and Transplantations presented at the 55th annual meeting of the Southern Medical Association held November 6-9 at Dallas.

Florida physicians participating in the program of the Ninth Annual Diabetes Seminar presented by the Florida Diabetes Association October 18-20 at Miami Beach included Dr. Morris B. Seltzer of Daytona Beach, president of the Association; Dr. Theodore F. Hahn Jr. of Deland, president-elect; Dr. George H. Garmany of Tallahassee; Dr. Sidney Davidson of Lake Worth; Dr. Fred Mathers of Orlando, and Drs. A. Gorman Hills and Joel B. Mann of Miami, and Drs. William C. Thomas Jr. and Joseph C. Shipp of Gainesville.

Dr. Edward C. Burns Jr. of Lake Wales was a recent speaker at the luncheon meeting of the Lake Wales Rotary Club. Dr. Burns presented a film entitled "The Invisible Enemy," dealing with the subject of nuclear radiation and fallout.

The Third Annual Fall Meeting of the Florida State Surgical Division of the International College of Surgeons is being held December 1-2 at the University of Florida College of Medicine in Gainesville, according to announcement by Dr. Raymond J. Fitzpatrick of Gainesville, president. Dr. James A. McLeod of Orlando is program chairman. Guest speaker is Dr. John B. O'Donoghue, secretary and president-elect of the United States Section of the International College of Surgeons.

Dr. Edward Jelks of Jacksonville has been reappointed by Governor Farris Bryant as a member of the Duval County Hospital Board.

Dr. Dwight J. Wharton of Jacksonville attended the meeting of the Southern Tuberculosis Association and Thoracic Society at Hot Springs, Va., in September where he served as a member of the panel which discussed "Eradication, A Many Functioned Thing."

Senator George A. Smathers was guest speaker at the October meeting of the Broward County Medical Association held at the Pier 66 Yacht Club in Fort Lauderdale. At the September meeting, Col. George M. Knouf from Cape Canaveral discussed "Medical Support of Space Operations."

Dr. Walter W. Sackett Jr. of Miami attended a recent conference in Washington, D.C., on Diabetes and Arthritis sponsored by the U. S. Public Health Service. He is a special consultant.

A course in Principles in Rehabilitation of the Physically Handicapped will be given under the sponsorship of the University of Miami School of Medicine and the Rehabilitation Center for Crippled Children and Adults December 4-8. Dr. Pedro Arroyo, medical director of the Center, is in charge of the program.

A postgraduate course in "Current Concepts in Cardiology" by Dr. Bernard Lown of Boston is being presented by Mount Sinai Hospital of Miami Beach on November 27 - December 1. Evening sessions begin at 8:00.

Dr. William W. Trice Jr. of Tampa was guest speaker at the the September meeting of the Lake County Medical Society held at Leesburg. The title of Dr. Trice's address was "Defects in Blood Clotting Mechanism and Hypoafibrinogenemia."

MEETINGS

November

2nd Postgraduate Medical Seminar Cruise, Nov. 2-12, S. S. Hanseatic, College of Medicine, University of Florida, Gainesville

Seminar in Clinical Medicine and Surgery, Nov. 12, Hotel Robert Meyer, Jacksonville

Florida Urological Society, Nov. 3-5, The Inn, Ponte Vedra, Fla.

Florida Pediatric Society, Nov. 9-12, Cherry Plaza Hotel, Orlando

December

Florida Obstetric and Gynecologic Society, Dec. 3-4, Gault Ocean Mile Hotel, Fort Lauderdale

Florida State Surgical Division, International College of Surgeons, Dec. 1-2, College of Medicine, University of Florida, Gainesville

January

Seminar in Obstetrics and Gynecology, Jan. 11-12, College of Medicine, University of Florida, Gainesville

Conference of County Medical Society Presidents and Secretaries, Jan. 13-14, Hotel Robert Meyer, Jacksonville

Seminar in Pediatric Surgery, Jan. 25-27, College of Medicine, University of Florida, Gainesville

Midwinter Seminar in Ophthalmology and Otolaryngology, Jan. 28-Feb. 4, Hotel Americana, Miami Beach.

Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 411 applicants who took the examination of the Board held June 26-27, at Miami Beach, 355 passed and have been issued licenses to practice medicine in Florida. The names, towns, medical school and year of graduation of the successful applicants follow:

Alford, Donald Owen, Gainesville (U. Florida 1961)
Andreae, Robert Lee, Phoenixville, Pa. (U. Tennessee 1955)
Arbisi, Gaspare Ronald, St. Petersburg (U. Miami 1961)
Ariail, William Thomas, Cornelia, Ga. (M.C. Georgia 1955)
Arnas, George Manuel, Weirton, W. Va. (Jefferson M.C. 1956)
Arnoult, Mathew Blake, Memphis, Tenn. (U. Tennessee 1943)
Arrants, Jack E., Gainesville (U. Virginia 1959)
Atkin, Norman, Miami Beach (Ohio St. U. 1954)
Barnett, Andrew Felix, Tampa (U. Illinois Med. 1932)
Barofsky, Norman, Brooklyn (U. Geneva 1959)
Barrs, Jack Leonard, Jacksonville (U. Miami 1961)
Baumeister, Frank Johnson Jr., Miami (U. Miami 1961)
Benefield, Joseph Irwin, Lake City (U. de Nuevo Leon 1955)
Bennett, George Ernest Jr., Miami (U. Florida 1961)
Bercaw, Peter, Miami (U. Virginia 1956)
Berman, Aaron Melvin, Miami (Ohio St. U. 1960)
Bibb, William Johnson, Pensacola (U. Tennessee 1955)
Bonbrest, Helen Constance, Chicago (George Washington U. 1960)
Bookhardt, Alfred Leroy, (Col.) New Smyrna Beach (Howard U. 1957)
Booras, William Peter, Jacksonville Beach (U. Miami 1961)
Borden, Robert Starr, St. Albans, N.Y. (U. Florida 1961)
Bosacco, David, St. Petersburg (Hahnemann M. C. 1960)
Boyd, Greydon G., Delray Beach (Harvard M.S. 1928)
Brady, John Jennings, Dearborn, Mich. (Marquette U. 1954)
Brady, Paul Edgar, St. Petersburg (M.C. Virginia 1943)
Braunstein, Leonard, Boston (Chicago M.S. 1954)
Brenner, Richard Wolff, Fort Lee, N. J. (Columbia U. 1958)
Brewer, Philip Lee, Atlanta, Ga. (Emory U. 1961)
Brewer, Thomas Harrington, Miami (Tulane U. 1949)
Bronstein, Edwin Samuel, Forest Hills, N. Y. (St. U. of New York 1959)
Broussard, William Joseph, San Francisco (U. Minnesota 1959)
Bryan, Ruepert Don, Orlando (U. Mississippi 1960)
Buckner, Charles Marbury Jr., Durham, N. C. (U. Florida 1958)
Burns, Marshall A., Jacksonville (Tulane U. 1961)
Burns, Matthew Lynwood, Lake City (Emory U. 1961)
Burquest, Bret Owen, Philadelphia (U. Miami 1961)
Cacciatore, Henry Anthony, Tampa (U. Miami 1961)
Calise, Peter Joseph, Columbia, Mo. (Washington U. 1955)
Carbonara, Francis John, Hampton, Va. (Bologna U., Italy 1952)
Carbonell, Manuel Luis, Miami (Marquette U. 1958)
Carducci, Alexander Thomas, Orlando (Wayne U. 1955)
Carr, Charles Adrian, Miami (St. Louis U. 1958)
Carter, Robert Alfred, Lake Park, Ga. (M.C. Georgia 1960)
Cassidy, Wiliam John, Miami (Georgetown U. 1960)
Cavanagh, Denis, Coral Gables (Glasgow U., Scotland 1952)
Childress, Robert C., Gainesville (Indiana U. 1954)
Chisholm, Leslie Lee Jr., Tampa (U. Nebraska 1960)

Clark, Joel Arnold Jr., New York (U. Virginia 1956)
Clayton, Jill Marshall, Jacksonville (U. Birmingham, Eng. 1955)
Clemente, Celestino, Glen Ridge, N. J. (U. Pennsylvania 1945)
Cochran, Emerson Bryan, Augusta, Ga. (M.C. Georgia 1959)
Cohen, Murray Neil, Brooklyn (New York M.C. 1961)
Cohen, Samuel Moses, Staten Island, N. Y. (U. Miami 1961)
Cohen, Saul Herbert, Charleston, S.C. (U. Florida 1961)
Condo, Frederick Joseph, Miami (U. Miami 1961)
Cooksey, Edwin Van, Miami (Emory U. 1961)
Cooley, Stephen Girard Earle, New York (U. Pennsylvania 1948)
Copeland, Clyde Xenophon Jr., Gainesville (Tulane U. 1959)
Cotton, Bernice Philip, Panama City (U. Miami 1961)
Cox, Charles W., Miami (U. Tennessee 1960)
Cox, Daniel Baker, Gainesville (U. Miami 1961)
Crawford, Porter Foskett, Kalamazoo, Mich. (Western Reserve 1946)
Crews, Roger Daniel Jr., Houston, Texas (Baylor U. 1955)
Crowley, Herbert Reily, Miami (Boston U. 1960)
Crum, Patricia Swearingen, Ocklawaha (U. Pennsylvania 1957)
Cushner, Gilbert Bernard, Coral Gables (U. Maryland 1958)
Dalton, John Joseph Jr., Bryn Mawr, Pa. (U. Vermont 1960)
Das Neves, Fernando, Chattahoochee (U. Brazil 1946)
David, Ronald Francis, Miami (Bowman Gray 1961)
Davis, James Karnes, Gainesville (Duke 1960)
Dickhaus, Alfred Joseph, Gainesville (U. Florida 1961)
Dismukes, William Paul Jr., Miami (Washington U. 1960)
Dillman, Richard Sherwood, Ann Arbor, Mich. (U. Michigan 1956)
Ditmore, Harry Boaz Jr., Fort Knox, Ky. (Harvard 1953)
Donelan, Richard Thomas, Lake City (Tufts 1949)
Donelson, Martin Jr., Danville, Va. (U. Virginia 1942)
Downey, James Lewis, New York (Columbia U. 1960)
Dunn, Harrison, Miami Beach (U. Amsterdam, Holland 1958)
Dunn, Worth Isom, Tampa (U. Tennessee 1950)
Duperret, Donald Lucien, Washington, D.C. (Cornell M.C. 1957)
Duvoisin, Peter Marc, Clearwater Beach (Duke U. 1960)
Dyke, Charles Jan, Washington, D. C. (Cornell 1960)
Eardley, Donald Keith, Gainesville (U. Arkansas 1957)
Elder, Sam Fletcher Jr., Miami (U. Miami 1961)
Ellerman, Norman, Miami (U. Miami 1961)
Erbs, Ronald Charles, Miami Springs (U. Miami 1961)
Evans, Geoge Holden, Fort Meade (U. Miami 1961)
Evans, Joseph Salvator, Opa Locka (Albert Einstein M. C. 1961)
Fajardo, Lydia Soler, Miami (Temple 1960)
Fausnaugh, Cloyde Lowell, Eau Gallie (U. Pennsylvania 1951)
Fein, Arthur Leonard, Baltimore (Bowman Gray 1959)
Feldman, Hobart Theodore, Allentown, Pa. (U. Pittsburgh 1946)
Feldman, Mark, Brooklyn (U. Miami 1961)
Feldman, Martin Preville, Coral Gables (Harvard 1955)
Fellner, Donald Weber Sibley II, Houston, Texas (U. Florida 1961)
Ferguson, Kenneth Griffith, Lakeland (U. Florida 1961)
Field, Roddy Allen III, Orlando (Emory 1957)
Fischer, Frank John, Babson Park (U. Florida 1961)
Fletcher, Gerald Floyd, Statesboro, Ga. (Emory 1961)
Fletcher, Robert Rowland, Savannah, Ga. (U. Puerto Rico 1955)
Flipse, Elizabeth Ann Randolph, Miami (Washington U. 1959)
Fogel, Bernard J., Coral Gables (U. Miami 1961)
Forest, John Alexander Johnson Jr., Dover, Del. (Temple 1953)
Fort, Lynn II, West Palm Beach (Duke 1960)
Fowler, Charles III, Orlando (U. North Carolina 1956)
Frederick Albert Roland Jr., St. Petersburg (Harvard 1961)
Frey, Walter Willis, Miami (Harvard 1960)
Friedgood, Charles Edward, Brooklyn (Wayne U. 1946)
Friedman, Gilbert Roy, Coral Gables (Tufts 1955)
Fry, Willard Arthur, Chicago (Northwestern U 1959)
Fulton, Kenneth Ervin, Vero Beach (U. Miami 1961)
Gagliano, Theodore Edmund, Palm Harbor (Columbia P & S 1951)
Garoni, William Joseph Jr., Decatur, Ga. (Emory 1961)
Garrett, Roland Gravatt Jr., Amelia, Va. (M.C. Virginia 1958)
Gaub, Margaret Luise, Miami (U. Washington 1960)
Gentsch, Thomas Otto, Coral Gables (Yale 1953)
Gerson, Gordon Neil, Coral Gables (Emory U. 1961)
Gertler, Philip Ervin, Atlanta (Emory 1961)
Gessner, Ira Harold, Gainesville (U. Vermont 1956)
Gianos, Sam Nicholas, Miami (U. Miami 1961)
Gillespie, Walter Foster, Albany, Ga. (U. Missouri 1957)
Glantz, William Morton, Philadelphia (U. Pennsylvania 1955)
Glenn, James Eugene, Jacksonville (U. North Carolina 1955)

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Glick, Harold, Pittsburgh (U. Pittsburgh 1957)
Goeller, Victor Russell Jr., New Orleans (Tulane 1954)
Golder, Harold Kromer, Tampa (U. Colorado 1954)
Goldman, Meyer Leo, Far Rockaway, N. Y. (U. Maryland 1933)
Gonzalez, Joe Victor, Charleston, S.C. (U. Florida 1961)
Gore, Tom Winfield, Durham, N. C. (Duke 1955)
Grady, John L., St. Petersburg (Creighton U. M. S. 1960)
Grahl, Arthur John, Rockledge (New York M.C. 1961)
Green, Richard, New York (Johns Hopkins 1961)
Green, Robert, Palm Beach (Duke 1960)
Green, Robert Lee Jr., Durham, N.C. (Hahnemann 1946)
Gresham, Jack Lewis, Orlando (U. Miami 1961)
Griner, Joseph Howard, Decatur Ga. (Emory 1956)
Gross, Bernard, Birmingham, Ala. (U. Lausanne 1960)
Grossman, Stanley Lawrence, Jacksonville (St. U. New York 1954)
Gruendel, Donald Peter, Tampa (Loyola 1954)
Guiney, Edwin Wesely, Canton, Mass. (Western Reserve 1954)
Hamilton, Edwin Harvey, (Col.) Dayton, Ohio (Meharry 1959)
Hampton, James E., Murfreesboro, Tenn. (U. Tennessee 1954)
Hatcher, William Wade, Memphis, Tenn. (U. Tennessee 1959)
Havens, William Orvil, West Palm Beach (U. Texas 1960)
Hayes, Robert Lee Jr., Orlando (M.C. Alabama 1960)
Heine, Melvin Wayne, Gainesville (Duke 1958)
Hendrix, Vernon Johnston, Atlanta, Ga. (Emory 1957)
Henry, Walter John, New York (New York M.C. 1952)
Hill, Hugh M., Gainesville (Johns Hopkins 1952)
Himmel, Marvin, Miami (U. Western Ontario 1956)
Hines, Robert Bruce, Uhrichsville, Ohio (Ohio State U. 1940)
Hoffman, William Perry, Fort Carson, Colo. (U. Rochester 1956)
Hoffner, Burton Paul, Forest Hills, N.Y. (New York M.C. 1961)
Hoopingarner, Newman Avery, Philadelphia (New York U. Coll. Med. 1945)
Horne, Hoyt, Jackson, Miss. (U. Florida 1961)
House, Edwin Keenan Jr., Gainesville (U. Florida 1961)
Howell, George Washington, Fulton, Miss. (U. Mississippi 1958)
Hudson, Richard Carl, Miami (Ohio State U. 1959)
Jacobson, Sanford, Miami (U. Miami 1961)
Jerkins, Henry Robert Jr., (Col.) Miami (Howard U. 1946)
Johnson, John Walter Carlysle, Baltimore (U. Virginia 1953)
Jones, Carlton Edward, Dunedin (M.C. Georgia 1953)
Judd, Allyn Francis, Whitesburg, Ky. (U. Maryland 1947)
Kahn, Alvin Jerome, Elizabeth, N. J. (Bowman Gray 1946)
Kane, Murray Lee, Miami Beach (U. Miami 1961)
Kaplan, Arnold Aaron, Miami (U. Illinois 1960)
Katibah, Edmund Mitchell, Jacksonville (Emory 1961)
Katz, Aaron Simeon, Miami Beach (Ohio State 1960)
Katz, Henry Edward, St. Petersburg (Sch. Med. Royal Col. Edinburg 1942)
Katz, Jack Leon, Miami (Albert Einstein Coll. Med. 1960)
Kaufman, Herbert Edward, Brighton, Mass. (Harvard M.S. 1956)
Keeler, Priscilla Anne, Birmingham, Ala. (M. C. Alabama 1960)
Kirschenbaum, M. Barry, Chicago (U. Chicago 1957)
Kleit, Stuart Allen, Indianapolis (U. Florida 1961)
Knight, Jimmie Harris, Pensacola (U. Miami 1961)
Knight, Wallace Archibald, Vero Beach (U. Buffalo 1957)
Krestow, Victor Philip, Atlantic Beach, N. Y. (St. U. of New York 1961)
La Mure, David Sylvester, Miami (St. Louis U. 1960)
Langhorne, William Henry, New Orleans (Tulane 1957)
Langston, Randall Autrey, N. Charleston, S. C. (U. Miami 1961)
Laplatney, Donald Robert, Jacksonville (U. Buffalo 1960)
Ledbetter, Jesse Rayburn, Pensacola (Tulane 1954)

Announcing The Twenty-Fifth Annual Meeting

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters — Roosevelt Hotel

March 12, 13, 14, 15, 1962

GUEST SPEAKERS

E. M. Pepper, M. D., New York, N. Y.
Anesthesiology
Edward P. Cawley, M. D., Charlottesville, Va.
Dermatology
Julian M. Ruffin, M. D., Durham, N. C.
Gastroenterology
Carroll L. Witten, M. D., Louisville, Ky.
General Practice
Howard J. Jones, Jr., M. D., Baltimore, Md.
Gynecology
Thomas M. Durant, M. D., Philadelphia, Pa.
Internal Medicine
Maxwell M. Wintrobe, M. D., Salt Lake City, Utah
Internal Medicine
Bernard J. Alpers, M. D., Philadelphia, Pa.
Neurology
Ralph C. Benson, M. D., Portland, Ore.
Obstetrics
Victor A. Byrnes, M. D., St. Petersburg, Fla.
Ophthalmology
John H. Moe, M. D., Minneapolis, Minn.
Orthopedic Surgery
Albert C. Furstenberg, M. D., Ann Arbor, Mich.
Otolaryngology
Jeff Minckler, M. D., Denver, Colo.
Pathology
Lewis L. Coriell, M. D., Camden, N. J.
Pediatrics
Robert D. Moreton, M. D., Fort Worth, Texas
Radiology
John H. Mulholland, M. D., New York, N. Y.
Surgery
Owen H. Wangensteen, M. D., Minneapolis, Minn.
Surgery
John L. Emmett, M. D., Rochester, Minn.
Urology

SPECIAL WEDNESDAY NIGHT GUEST

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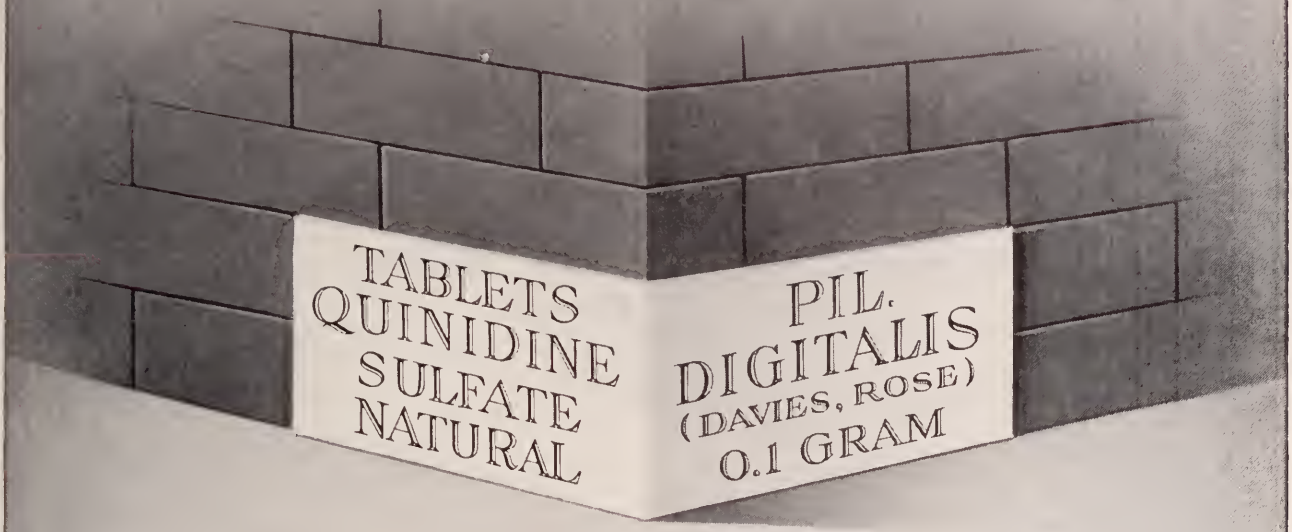
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(Optional extensions may be arranged)

For information concerning the Assembly meeting and the tour write Secretary, Room 105, 1430 Tulane Avenue, New Orleans 12, La.

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Lee, William Harrell, Augusta, Ga. (Emory U. 1954)
Lerman, Stuart, Miami (U. Illinois 1960)
Lev, Daniel M., Brooklyn (Vanderbilt 1961)
Levine, Alan Samuel, St. Petersburg (U. Miami 1961)
Litowitz, Norman Stanley, San Francisco (Northwestern 1961)
Livingston, Robert Michael, New York (Yale 1961)
Locicero, Felix, Tampa (U. Miami 1960)
Loev, Marvin, Orlando (U. Pennsylvania 1959)
Lovegrove, Robert Harry, Wayne, Mich. (U. Michigan 1959)
Lubin, Martin Isadore, Miami Beach (U. Miami 1961)
Ludwig, William Michael, New York (New York U. 1961)
Lybass, Tillinghast Goethe, Jacksonville (Duke 1961)
Madry, James Thomas, Augusta, Ga. (M. C. Georgia 1958)
Malawer, Sidney Joel, Gainesville (U. Chicago Med. Sch. 1960)
Mann, Milton Bernard, Eglin AFB (U. North Carolina 1956)
Markham, Charles Whitlow, Tampa (Washington U. 1955)
Martin, Gilbert Adrian, Jr., Haddonfield, N. J. (Jefferson 1954)
Martz, Willard Harry, Miami Beach (Temple U. 1960)
Mase, Darrel Jay Jr., Gainesville (U. Miami 1961)
Mason, John Franklin Jr., Mobile, Ala. (U. Florida 1961)
Massaro, Angelo, Miami (U. Miami 1961)
Masters, Leonard Eugene, Jacksonville (U. Miami 1961)
Mazzarella, John A., Miami (Cornell 1958)
McCloy, Dixon Ross, Monticello, Ark. (U. Arkansas 1951)
McClure, Harold McKinley, Coral Gables (Northwestern U. 1929)
McCurdy, Charles Milton, Charleston, S. C. (U. Florida 1961)
McCutcheon, Ernest Parrish, St. Petersburg (Duke 1959)
McDermott, John Francis Jr., Ann Arbor, Mich. (New York M.C. 1955)
McGlamory, James Clayton, Jacksonville (U. Florida 1961)
McGough, Edwin Clifford, Miami (Tulane U. 1961)
McKee, William Ford Jr., Rockville, Md. (U. Virginia 1959)
Mergenthaler, Dean Dana, Miami Beach (Jefferson M. C. 1960)
Merritt, Francis Lincoln Jr., Bethesda, Md., (Yale 1951)
Meyer, John Edward, St. Petersburg (U. Miami 1961)
Miles, Eunice Barbara, Fort Lauderdale (New York U. 1953)
Miller, David Herman, Orange, Va. (M. C. Virginia 1946)
Miller, Frank Richard, Decatur, Ga. (Emory 1961)
Mills, Herbert Robin, Ponce, Puerto Rico (U. Miami 1961)
Milman, Leroy, Opa Locka (U. Miami 1961)
Moffitt, Lloyd Vincent Jr., West Palm Beach (U. Miami 1961)
Monson, Donald Malvin, Ft. Jackson, S. C. (U. Wisconsin M. S. 1955)
Moore, Paul Harold, Gainesville (U. Mississippi 1959)
Moraca, John Idolo, Miami Beach (U. Pittsburgh 1959)
Muniz, Antonio Manuel, Jacksonville (U. Miami 1961)
Munoz, Hernando, Tallahassee (Natl. U. Columbia 1950)
Muntz, Keith Stickler, Rochester, Minn. (Western Reserve 1955)
Myers, William George, Bethel Park, Pa. (U. Pittsburgh 1956)
Newman, Lawrence Emanuel, Los Angeles (U. Miami 1961)
Norris, Virgil Croom, (Col.) Tallahassee (Meharry M. C. 1959)
Northcott, Eugene Francis, Miami (U. California 1960)
Overstreet, Troy Elkin, Coral Gables (U. Miami 1961)
Patterson, Matthew Charles, Clearwater (U. Florida 1961)
Peacock, William Franklin III, Bartow (Emory 1961)

(Continued on page 479)

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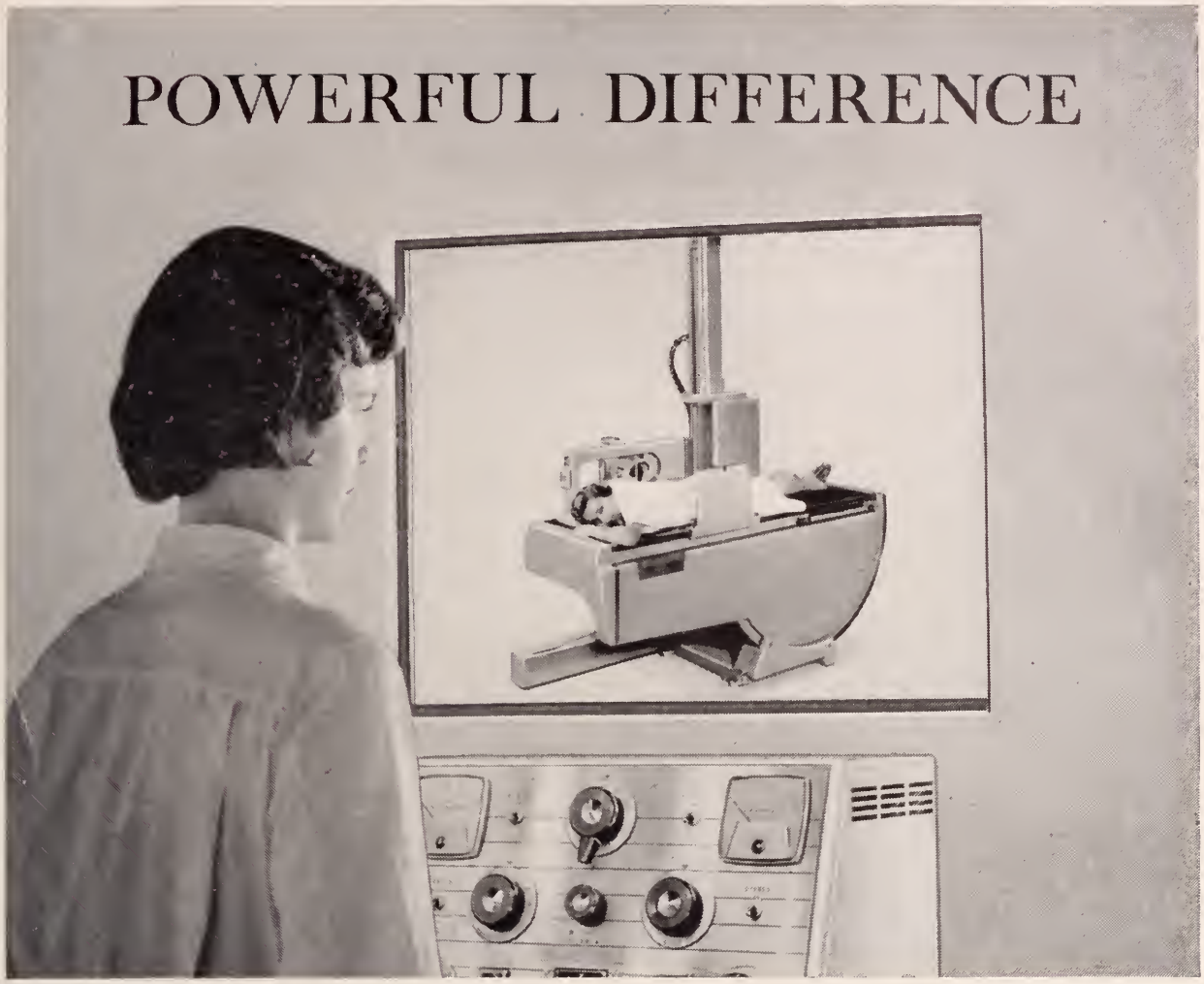
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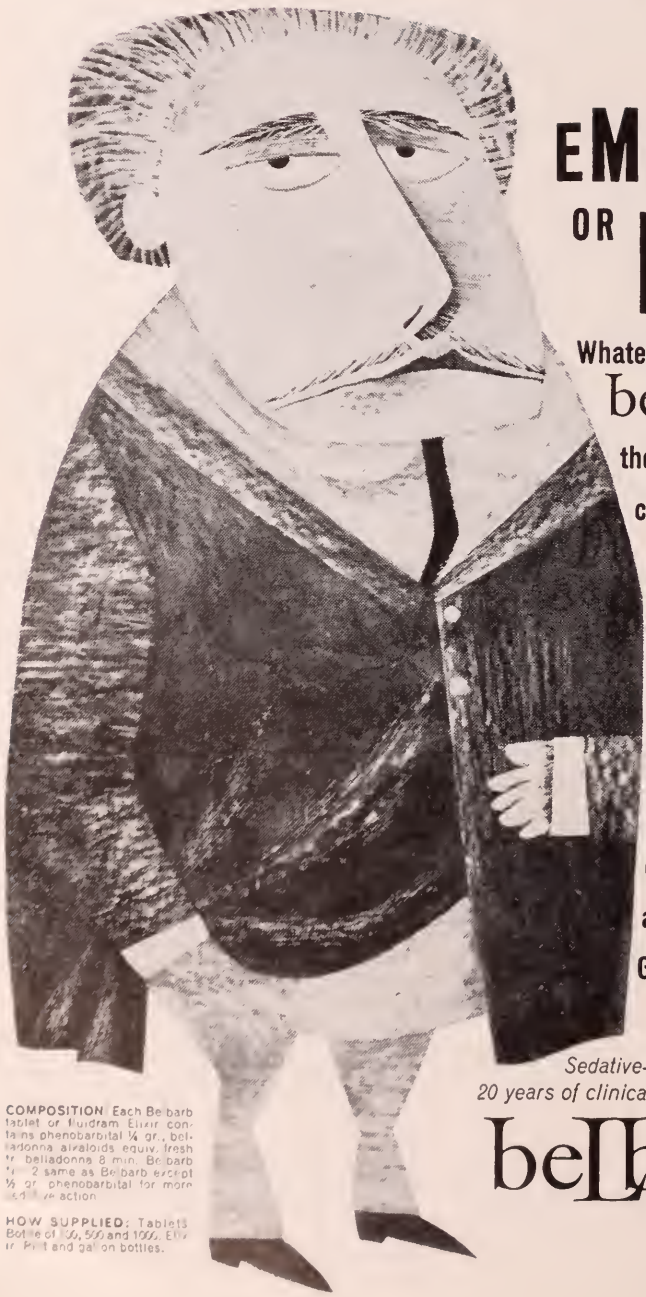
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Pendergrass, Lloyd Herbert, Orlando (U. Louisville 1960)
Perkins, Haven Meade, Gainesville (U. Louisville 1943)
Perlman, Morton Allan, Chicago (U. Miami 1961)
Perrine, George Alden Jr., Columbus, Ohio (U. Florida 1961)
Peter, Charles Scudder Jr., Mobile, Ala. (Tulane 1954)
Peterson, Norman Doan, Hallandale (Johns Hopkins 1961)
Pickering, Michael Joseph, Gainesville (U. Florida 1961)
Pirkle, Thomas Nelson, Jacksonville (M.C. Georgia 1956)
Platock, Gerald Marvin, Jacksonville (M.C. Georgia 1956)
Pooley, Robert Earl, Miami (St. U. New York 1960)
Powell, James Whitlow, Nashville, Ga. (Emory 1961)
Pruett, Don Shelby, Miami (Missouri U. 1960)
Pulver, Sydney Earl, Media, Pa. (U. Pennsylvania 1953)
Punches, James Gilbert, Miami (Ohio St. Med. Sch. 1956)
Purvis, William Edmond III, Clearwater (Western Reserve U. 1945)
Quillian, Warren Wilson II, Coral Gables (Emory 1961)
Radzimski, Eugene Henry, Kenmore, N. Y. (U. Buffalo 1941)
Rahaim, John Joseph, Jacksonville (U. Miami 1961)
Randolph, John William, Orlando (U. Miami 1961)
Ramsey, Howard Wayne, Gainesville (U. Florida 1961)
Raszus, George Charles, Sherman Oaks, Calif. (Wayne State U. 1953)
Ravel, Richard, Miami (Columbia Col. Phys. & Surg. 1960)
Rayman, Russell Barry, Miami Beach (U. Michigan 1961)
Reed, Ralph Eugene, Portsmouth, Va. (U. Miami 1961)
Reese, Owen Jr., Decatur, Ga. (Duke U. 1957)
Resnik, Sorrel, Miami (Vanderbilt 1961)
Rissler, Herbert Leon Jr., Riviera Beach (U. Basel, Basel Switzerland 1959)
Robbins, James Elbert, Gainesville (Emory U. 1960)
Roberson, Clive Ervin, Palatka (Duke U. 1961)
Rodriguez, Fernando, Hialeah (U. Puerto Rico 1955)
Roginsky, Alan, Cleveland (Western Reserve U. 1956)
Roginsky, Martin Sydenkam, Scarsdale, N. Y. (Western Reserve U. 1958)
Rowland, John Henry Jr., Miami (New York 1956)
Ryon, Robert Judson, Coral Gables (U. Miami 1961)
Salmon, David Lee Jr., St. Petersburg (U. Florida 1961)
Sammons, Billy Proctor, Hot Springs, Ark. (Tulane U. 1952)
Sanchez, Joe Jr., Greensboro, N. C. (U. Florida 1961)
Sanders, Roma John Jr., Indianapolis (U. Miami 1961)
Sapp, Edgar Wilber, Orlando (U. Florida 1961)
Savage, Dorothy Louise, Vero Beach (New York M. C. 1953)
Savin, Ronald Clifford, Coral Gables (U. Florida 1961)
Sbar, Sheldon, Miami Beach (U. Florida 1961)
Scanlon, Wilson George, Jacksonville (Long Island Col. Med. 1941)
Scheib, Ronald Joseph, Los Angeles (U. Miami 1961)
Schoenfeld, Eugene Leonard, Coral Gables (U. Miami 1961)
Schulman, Stephen Alan, Miami (U. Miami 1961)
Schultz, Richard Dwayne, Miami (Missouri 1960)
Schwartz, John Theodore, Norfolk, Va. (Jefferson 1955)
Schwarz, George Carl, Gainesville (Duke 1960)
Scott, John Sewell, Orlando (London 1947)
Seinfeld, Barry Melvin, Miami (Miami 1961)
Shafron, Richard David, Miami (Northwestern 1961)
Shames, Jay Morton, Orlando (Tulane 1961)
Shannon, Gordon James, Detroit (U. Miami 1961)
Shiflet, Robert Edwin, Orlando (Georgia 1943)
Shries, Dana LeRoy Jr., Gainesville (U. Florida 1961)
Siegel, George Jacob, Miami Beach (U. Miami 1961)
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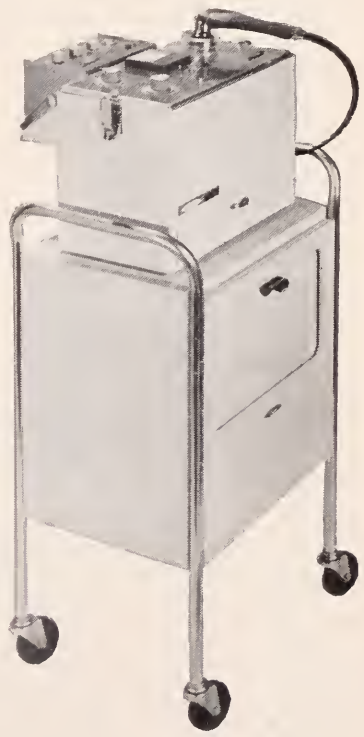
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Smith, Patrick Henry, Ocala (Georgia 1924)
Sommer, David Abraham, Miami (Pennsylvania 1960)
Sorsdahl, Oliver Allen, Gainesville (Florida 1961)
Spitzer, Norman Charles, Jacksonville (Florida 1961)
Sprehe, Daniel Joseph, Kansas City, Kan. (Oklahoma 1957)
Stampa, Julian Meinhard, St. Petersburg, (Berlin 1945)
Standard, Roger Alvie, Long Beach, Calif. (Med. Evang. 1941)
Stein, Sanford Wilbert, Forest Hills, N. Y. (New York M. C. 1960)
Stevenson, Arthur James, New Philadelphia, Ohio (Cincinnati 1953)
Stinebiser, James Henry, Cantonment (Miami 1961)
Storter, Barry Mitchell, Naples (Miami 1961)
Straub, Paul James, Miami (Miami 1961)
Stuber, Roscoe Vernon, Anna Maria (Columbia 1953)
Sussman, Howard Franklin, Miami Beach (Miami 1961)
Swain, Francis McKamey, Fort Lauderdale (Louisville 1942)
Tagudin, Angel Leano, Miami (U. Santo Tomas 1952)
Tankleff, Bert Norman, Hollywood (Marquette 1960)
Tatum, Lucian Lafayette Jr., Nashville, Tenn. (Vanderbilt 1961)
Taylor, Patrick Elsworth, Gainesville (Chicago 1954)
Terrell, Charles Oliver, Tampa (Illinois 1960)
Thompson, James Robert, Lake Worth (Temple 1952)
Tomlinson, John Pitt III, Lake Wales (Emory 1961)
Tubbs, Frederick Eugene, Tampa (Emory 1961)
Vallee, Gerald Eugene, Detroit (Florida 1961)
Vanderbeek, Richard Robbins, Tenafly, N. J. (Jefferson 1958)
Varela, Fernando Luis, Chattahoochee (Havana 1951)
Vega, Paul Joseph, Orlando (Louisiana State 1956)
Venis, George Theodore, Miami (Miami 1961)
Verity, Gordon Lloyd, Gainesville (Michigan 1954)
Verwoerdt, Adriaan, Durham, N. C. (Amsterdam 1952)
Vroom, Frederic Quinby, Lakeland (M.C. Alabama 1961)
Waltzer, Arthur Kenneth, Nashville, Tenn. (Vanderbilt 1961)
Ward, Walter Chalmers, Winter Park (Med. Evang. 1960)
Warshaw, Joseph Bennett, Miami (Duke 1961)
Weathers, William Jr., Rome, Ga. (Miami 1961)
Weiss, Edward Ronald, Miami (Miami 1961)
Welch, Richard Burke, West Palm Beach (Florida 1961)
Wells, Thomas Leon, Gainesville (Vanderbilt 1956)
Weseley, Stephen Arthur, Brooklyn (St. U. New York 1961)
Westra, Pier, Minneapolis (Utrecht, Holland 1953)
White, Elga Bryan, West Palm Beach (Miami 1961)
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Whitehurst, William Westwood, Land O'Lakes (M. C. Virginia 1958)
Wholey, Mark Henry, Charleston, W. Va. (Hahnemann 1953)
Wilson, Charles Melvin, Gainesville (Miami 1961)
Wilson, John Lewis, Decatur, Ga. (Emory 1961)
Wirth, Wolfgang August, Norfolk, Va. (Frankfurt, Germany 1955)
Wisoff, Bernard George, Atlantic Beach, N. Y. (New York U. 1954)
Woodard, Otis Jack Jr., Hialeah (M.C. Georgia 1957)
Wunderlich, Warren Arthur, Miami (Illinois 1960)
Wynn, Ralph Matthew, New York (New York U. 1954)
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Woman's Auxiliary

Fall Conference and Board Meeting Helping Hands

Mrs. Harlan English, president of the Woman's Auxiliary to the American Medical Association, was honored guest and featured speaker at the Fall Conference and Board Meeting of the Woman's Auxiliary to the Florida Medical Association which convened at the Cherry Plaza Hotel in Orlando, October 17 and 18.

Mrs. English of Danville, Illinois, was installed as president of the WAAMA at the June Convention in New York. Active for many years in the Auxiliary, she has served as president of both her county and state auxiliaries. She has also served as treasurer, director, and second vice president of the National Auxiliary. She has been identified with a number of civic and health organizations in Danville, having served as a worker and in an executive capacity for the A.A.U.W., the Children's Home of Vermillion, the Red Cross, Day Nursery and the Lake View Hospital Auxiliary. Her husband, Dr. Harlan English is a noted urologist and an Illinois delegate to the AMA. Dr. and Mrs. English are both dedicated, untiring workers in their community and were honored for their service by being named Danville's "Man and Woman of the Year" in 1950.

Addressing the Board members and guests at the Continental Breakfast on Tuesday morning, Mrs. English spoke from the many years of her experience and the deep conviction that doctor's wives occupy a unique position in their community from which they can exert enormous influence for good. She pointed out that "far too

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many of us are members of churches, charitable and civic organizations in name only. We are financial contributors or dues paying members who give little service and less thought to policies developed or to the eventual outcome of courses of action taken by them."

Mrs. English asked that we re-examine ourselves as members of the groups to which we belong—and to put our knowledge, understanding, services and voice along with our names on the rolls. TO GIVE A HELPING HAND. To be a member in truth, with a concern and interest in every phase of their work. And, if necessary, to raise our hands in warning that "loss of individual responsibility, self reliance and the right to choose will ultimately result in the loss of freedom."

Setting a goal for Community service, Mrs. English urged that we "Let the helping hands of the doctor's wife reflect and enrich the dedicated service which the physician husband gives in each community."

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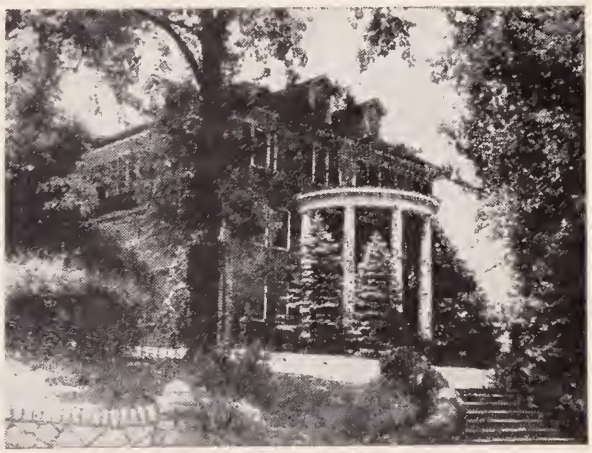
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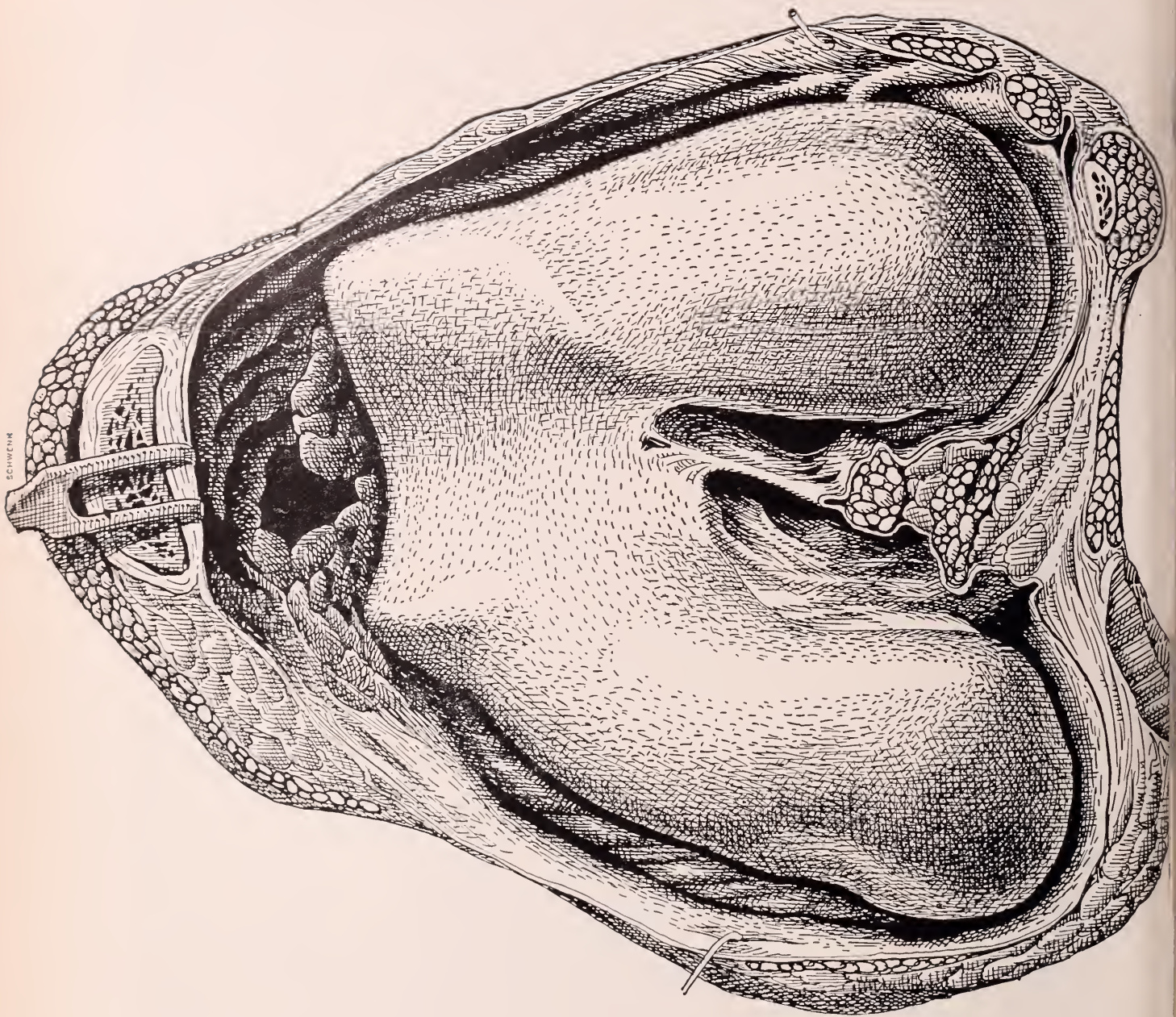
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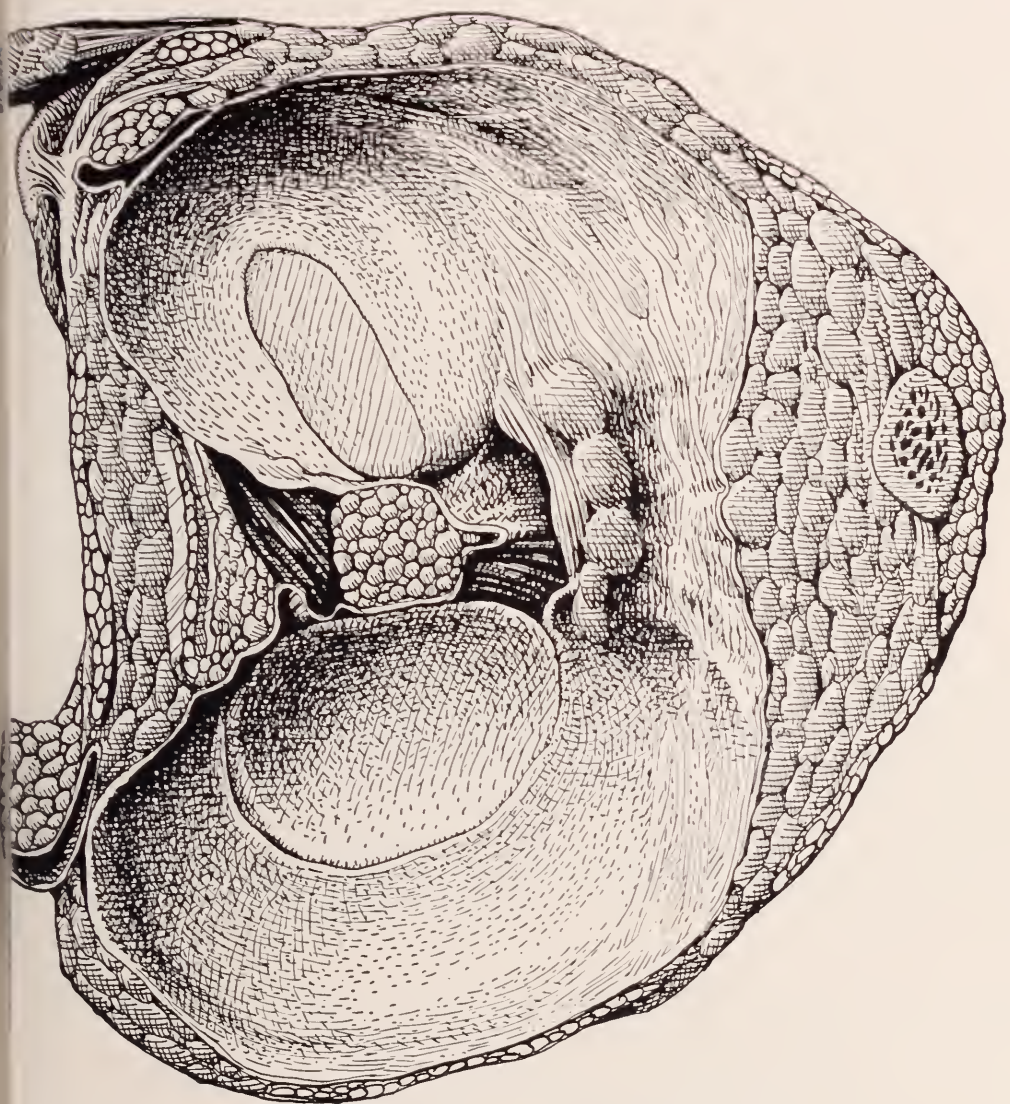
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BOOK REVIEWS

Cardiovascular Dynamics. By Robert F. Rushmer, M.D. Ed. 2. Pp. 503. Illus. 264. Price $12.50. Philadelphia, W. B. Saunders Company, 1961.

This book was originally published under the title of "Cardiac Diagnosis: A Physiologic Approach." Extensive revision, enlargement and reorganization in this second edition have resulted in a compact presentation of both normal and altered cardiovascular reactions.

This volume presents a comprehensive, progressive picture of the basic properties, functional anatomy, normal physiological reactions and reactions modified by disease states of the cardiovascular system. This is a book which will afford the medical student, graduate student and practitioner an excellent opportunity to learn and/or review the theories and laws of cardiovascular dynamics. Uncomplicated illustrations are freely used, and reference lists appear complete.

William J. Overman, M.D.

Relief of Symptoms. By Walter Modell, M.D., F.A.C.P. Ed. 2. Pp. 375. Illus. 5. Price $11.50. St. Louis, The C. V. Mosby Company, 1961.

The excellence of this book is shown by the fact that it is in its second edition. Although Dr. Modell starts out in his preface indicating that this is principally a discussion of treatment of symptoms, let no one misunderstand that this book is not a scholarly and critical presentation of drug therapy. Dr. Modell is extremely well qualified to handle this subject, being Director of Clinical Pharmacology and Associate Professor of Pharmacology at Cornell University, as well as attending physician at one of the Veterans Administration Hospitals in New York, and associate visiting physician at Bellevue Hospital. He is also a member of the General Committee on revision of the United States Pharmacopeia XVII, and Editor of Clinical Pharmacology and Therapeutics. This book is highly recommended to all physicians starting in practice. It is as up-to-date as any book can be, with the rapid advances of new drugs in the field of therapeutics. It is critical and evaluates old drugs and new drugs in their proper perspective. Physiology and pharmacology are briefly and coherently discussed, and at the end of each chapter a concise summation is present. The last chapter, the thirty-second, on Cortisone and maximum of symptoms, is excellent and well worth reading. To sum it up, in Dr. Modell's words: "This book is highly recommended as a critical evaluation of symptoms and their treatment by new and old drugs. It is not just a symptomatic treatment book but a discussion in concise form of basic pharmacology in only its practical aspects, based on the symptoms that the patient consults a doctor for and complains of." Again this book is highly recommended to all physicians starting out in practice, to interns, and to medical students, and is a useful book for the physician who has been in practice for many years and still likes to be a little critical of the value of new and old drugs.

Addison L. Messer, M.D.

Adrenergic Mechanisms. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 595. Price $12.50. Boston, Little, Brown and Company, 1960.

This international symposium on adrenergic mechanisms, sponsored by the Ciba Foundation, includes a host of highly technical communications covering a multitude of research interests from the formation and inactivation of adrenergic transmitters to the thought-provoking fact that the human brain and the liver fluke are about equally productive in producing cycloadenylic acid, and the "exciting story of the release of catechol amines by tyramine." For the serious student of adrenergic mechanisms, this volume represents the harvest of facts and theories of the most productive workers in this special field.

Earl M. Spaulding, M.D.

A Manual Of Cutaneous Medicine. By Donald M. Pillsbury, M.A., D.Sc. (Hon.), M.D., F.A.C.P. Walter B. Shelley, M.D., Ph.D., F.A.C.P., and Albert M. Kligman, M.D., Ph.D. Pp. 430. Illus. 234. Price $9.50. Philadelphia, W. B. Saunders Company, 1961.

This is another outstanding work from three well known writers in the field of dermatology. Although the authors refer to their book as a "manual," it is considerably more comprehensive than the word implies. It is likewise more than just a shortened version of the longer work published in 1956. The sections on physiology, chemistry, and anatomy of the skin, although fairly brief, contain a wealth of concise material. The book is almost equally divided between text and graphic

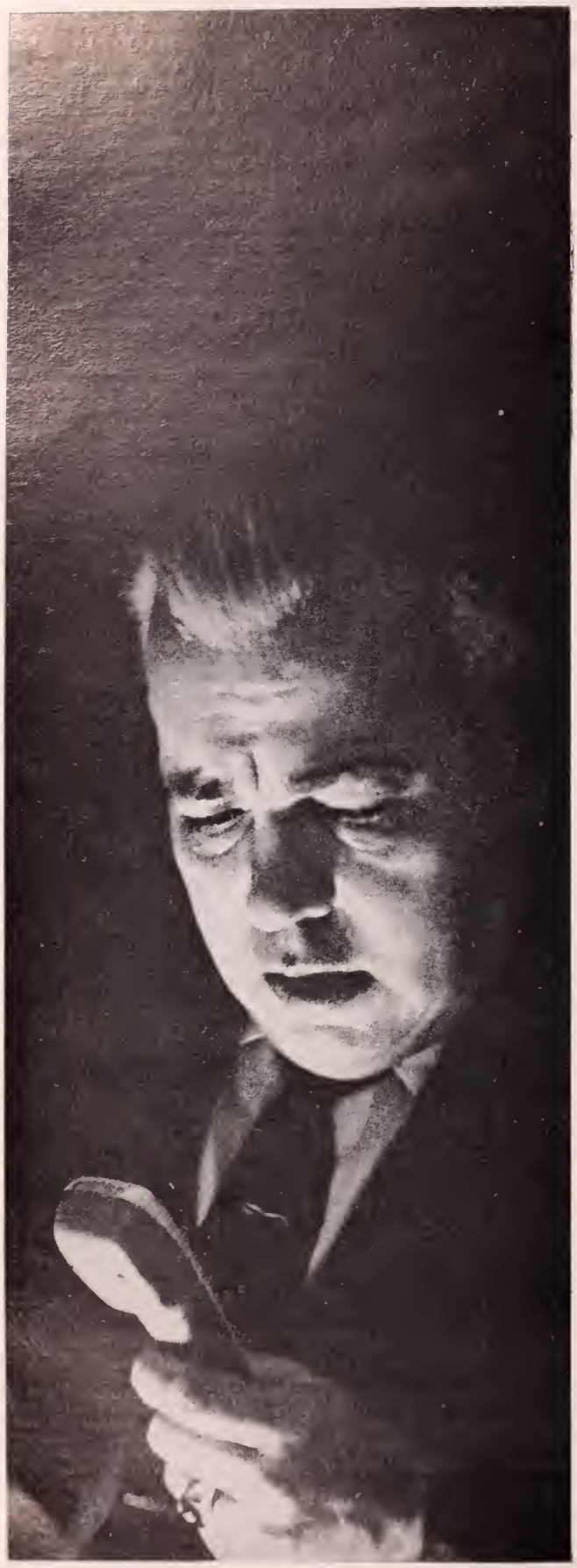


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material. Although no color plates are presented, the black and white photographs are above average, and possibly superior to many color plates which in some books are often old and photographically outdated. Nondermatologists will be gratified to know that Latin terminology and eponyms are avoided wherever possible.

Although written primarily for the practicing physician with emphasis on the more common skin disorders, the book is comprehensive enough to be of considerable value to the student and intern. The skin diseases are grouped and classified by etiology wherever possible. Morphology, distribution and differential diagnosis are often listed, or presented in summary form. Perhaps the most outstanding part of the book, and the most valuable to the general practitioner, is the concise and accurate summary of the indications, expected results, and hazards of corticosteroid therapy, both systemic and topical. This is presented in chart form with effectiveness and justification for use in most of the common skin disorders. This section alone should justify the purchase of the book by anyone engaged in treating skin disease.

W. E. Ryle, M.D.

Childbirth with Hypnosis. By William S. Kroger, M.D., edited by Jules Steinberg. Pp. 216. Price, $3.95. Garden City, N. Y., Doubleday & Company, Inc., 1961.

Written by a noted obstetrician and a pioneer in the field of hypnosis in childbirth, this book is the first authoritative introduction to this important new advance in obstetrics. It is a complete guide to what the expectant mother will experience—from the first visit to the doctor, through her pregnancy, to the delivery of her child—with hypnosis. The author discusses the background, technique, and advantages of using hypnosis in childbirth.

Handbook of Pediatrics. By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. Ed. 4. Pp. 374. Price 3.50. Los Altos, Calif., Lange Medical Publications, 1961.

The new edition of this well accepted reference handbook of pediatrics is more comprehensive than before, encompassing practically all aspects of pediatric practice. One is impressed with the up-to-date changes in concepts which have been included in the interim two years. As now revised, I believe this represents one of the best of such short-hand references.

It would seem that the section on fluid therapy could be simplified and more appropriately stress the principles of fluid replacement in infants and children. This edition, however, serves a real need and purpose adequately when amplified by more basic references of therapeutics. If one is aware of its limitations, the text deserves a place on the reference shelf.

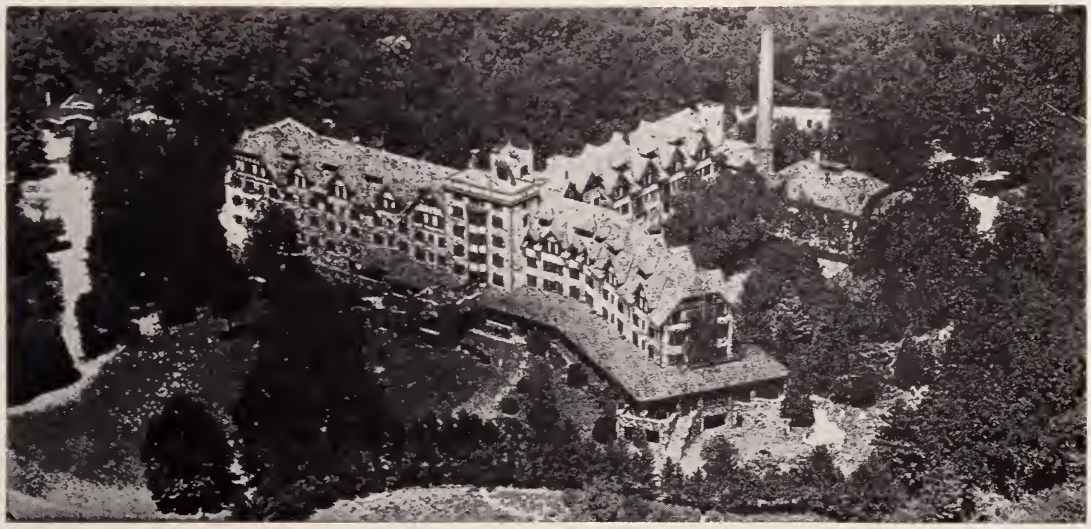
Reed Bell, M.D.

Resuscitation of the Newborn Infant: *Principles and Practice.* Edited by Harold Abramson, M.D. Pp. 274. Illus. Price, $10.00. St. Louis, The C. V. Mosby Company, 1960.

The 24 medical contributors to this treasury of information are all members of the Special Committee on Infant Mortality of the Medical Society of the County of New York. They each have exquisitely measured a most stimulating potion to this volume of literary tonic. The contents are not merely a smattering of learning but instead a combined epitome of experimental and practical knowledge regarding respiratory distress seen in the infant. Previously there had been no definitive program to prevent abnormal states of neonatal respiration, because those concerned had been distracted with the clinical aspects of pregnancy. Only of late has the pediatrician realized the importance of knowing the problems encountered by the obstetrician regarding the contents of the gravid uterus. Also only recently has the obstetrician become cognizant of the valuable services that his colleague the pediatrician may offer. Of course, the one who de-

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L. Lahey Clinic Bull. 11.12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.. Am. J. Med. 25 673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W . and Fong. T.C.C. In Stieglitz. E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.; Am. J. Med. 25:708 (Nov.) 1958.

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(Continued from page 488)

serves the most merit, but receives the least, is the anesthesiologist. The text is presented on the concept that the newborn must not be treated in a fragmental manner by the various specialists but instead by the collective endeavors of the specialists in toto. The contents is synergistically segregated into 17 chapters. One chapter is excitingly titled "The First Sixty Seconds of Life" and is concerned with direct observations of the newborn and the treatment administered for possible complication. It is apparent that every obstetrical delivery is an emergency until the baby has been safely adapted to its new environment. All in all, the book is a story of resuscitation of the infant and will be appreciated by the general practitioner, the pediatrician and the anesthesiologist.

Clifford C. Snyder, M.D.

Key and Conwell's Management of Fractures, Dislocations, and Sprains. By H. Earle Conwell, M.D., F.A.C.S., adn Gred C. Reynolds, M.D. Ed. 7. Pp. 1153. Illus. 1227. Price, $27.00. St. Louis, The C. V. Mosby Company, 1961.

In this seventh edition of this monumental work, Dr. Fred C. Reynolds, who was associated with Dr. J. Albert Key and who is now his successor as Professor of Orthopedic Surgery at Washington University School of Medicine, participates as co-author. This revision continues to stress the importance of looking upon the injured individual as a whole being and to emphasize selective injuries with sound methods used in their treatment. The book has been thoroughly revised. More detailed discussions of deceleration injuries and spinal disk involvement have been included. A discussion of treatment with the medullary nail has been presented, and indications for its use, based on thorough investigation, have been included. Also, the use of the hip prosthesis has been discussed. The text and illustrative material have been presented in such a way that the book will be of great use.

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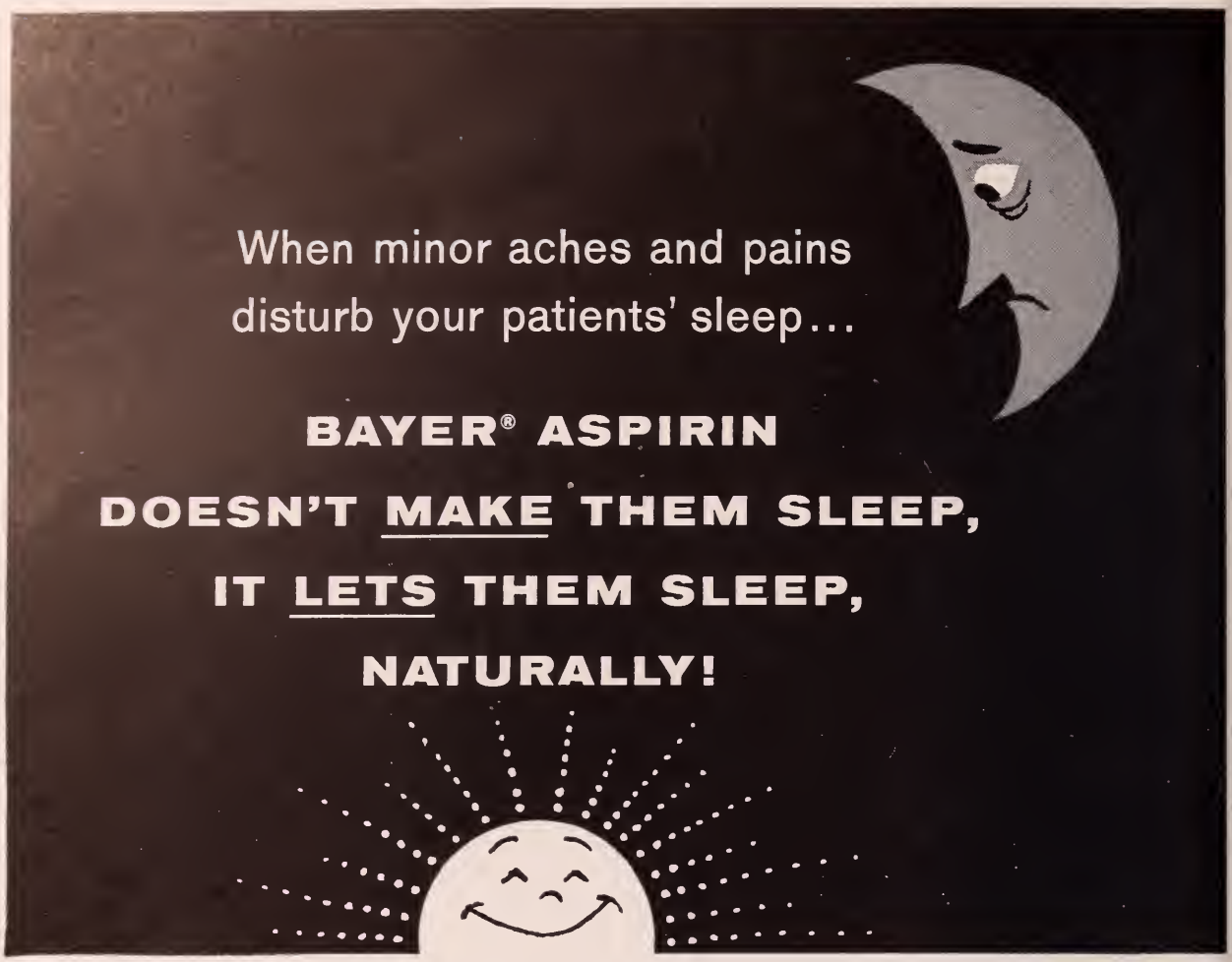
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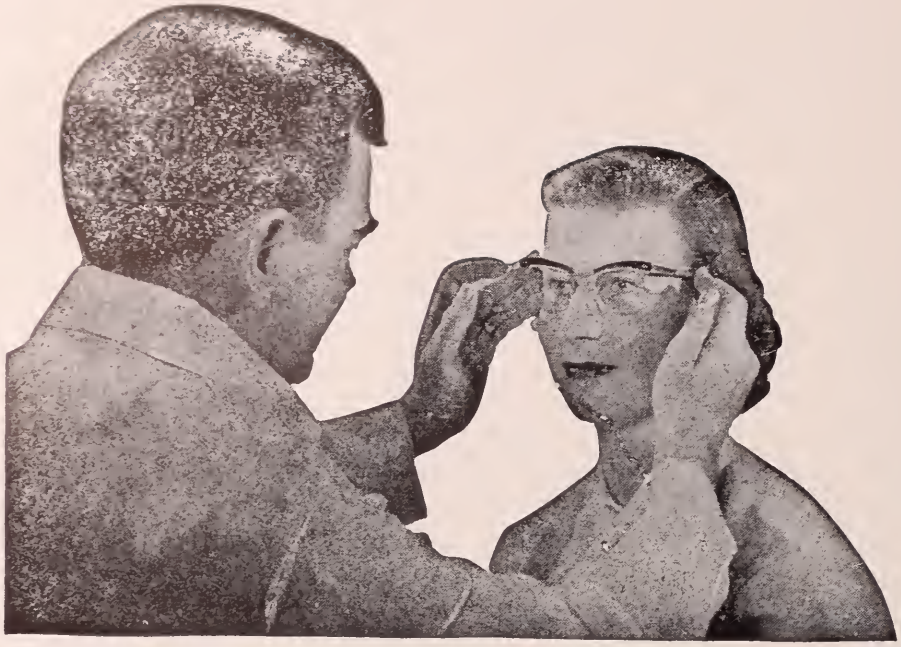


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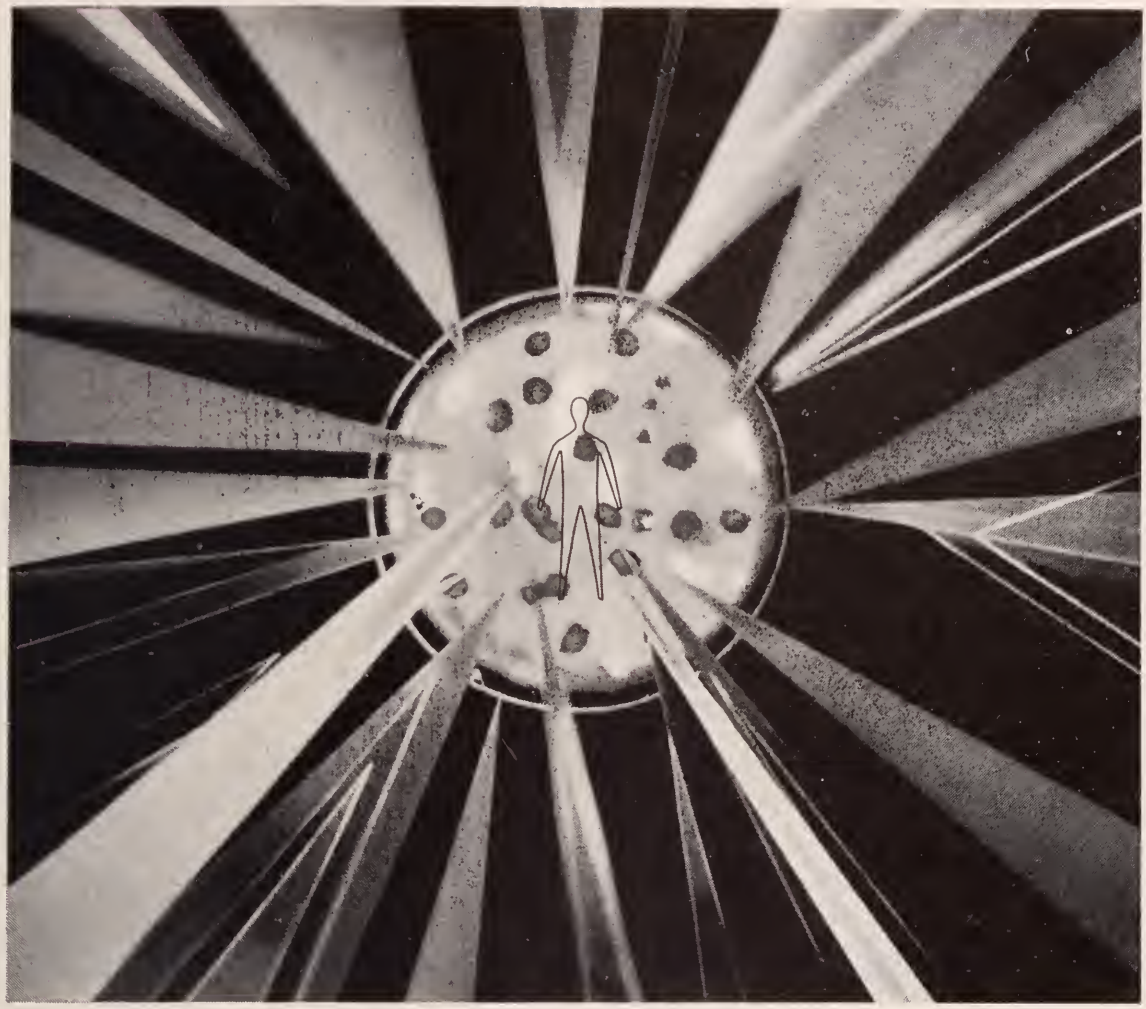
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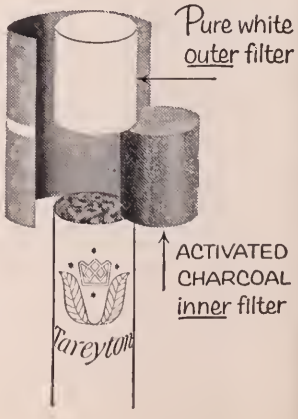
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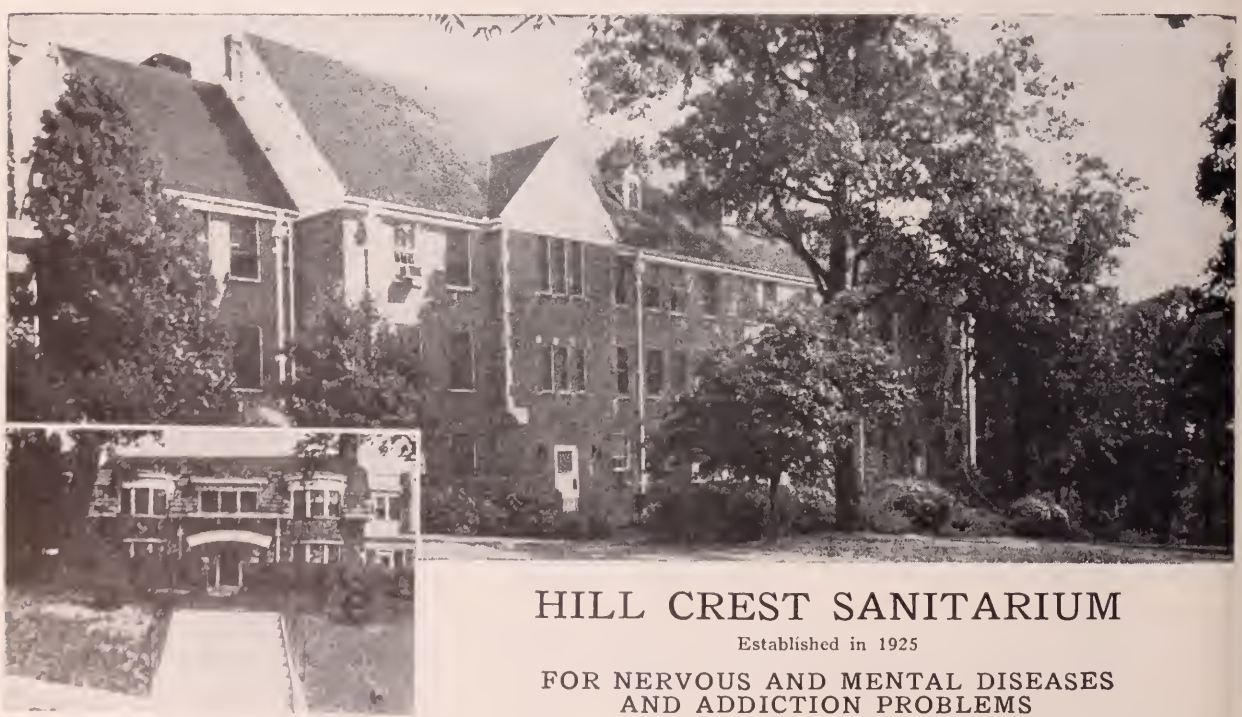
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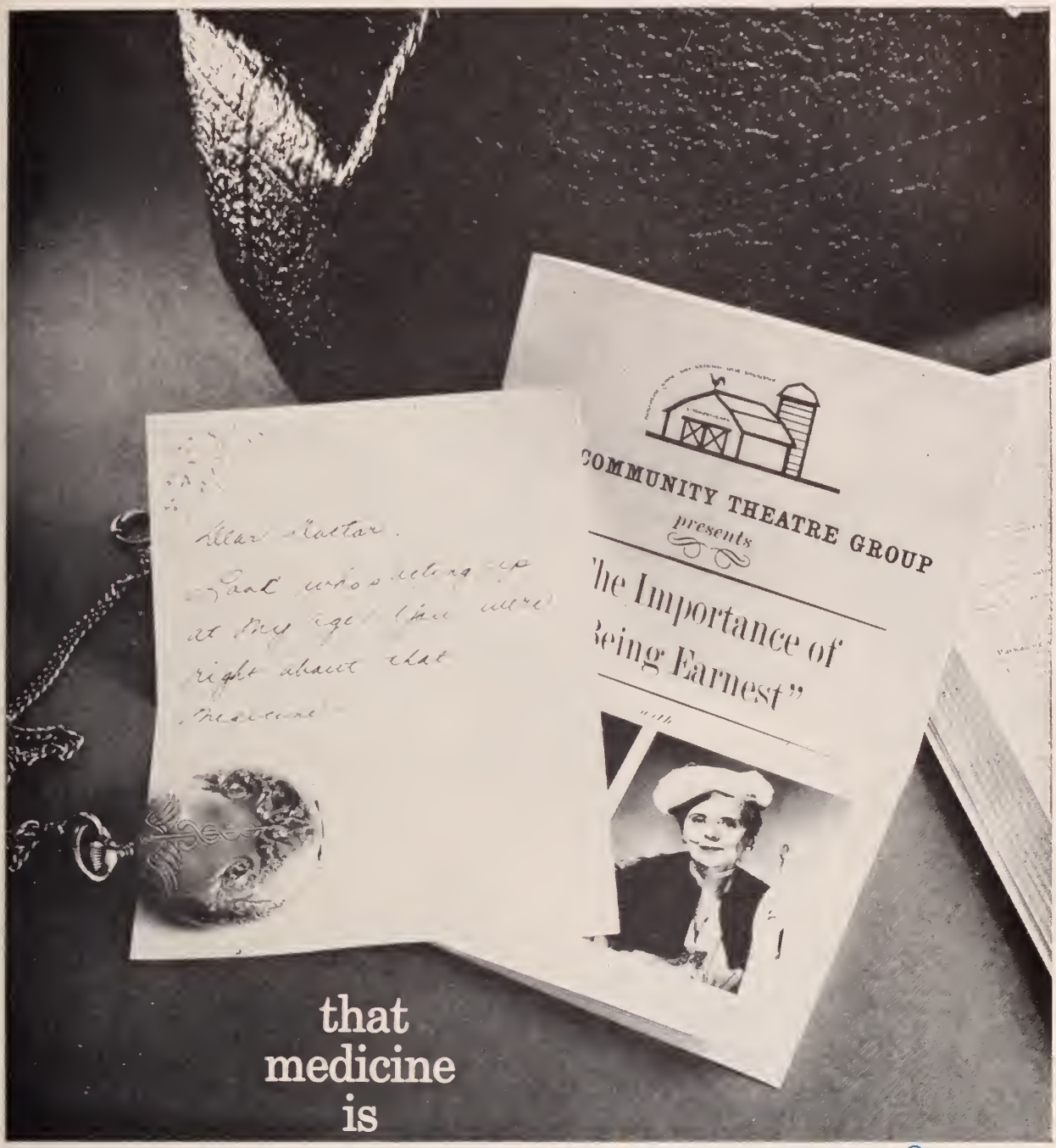
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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Bibliography: (1) Jacobs, I.: GP *21*:93 (Jan.) 1960. (2) Shulman, I.: J.A.M.A. *175*:118-123 (Jan 14) 1961. (3) Moore, C. V., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, p. 243.

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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VOLUME XLVIII, No. 6

• *December, 1961*

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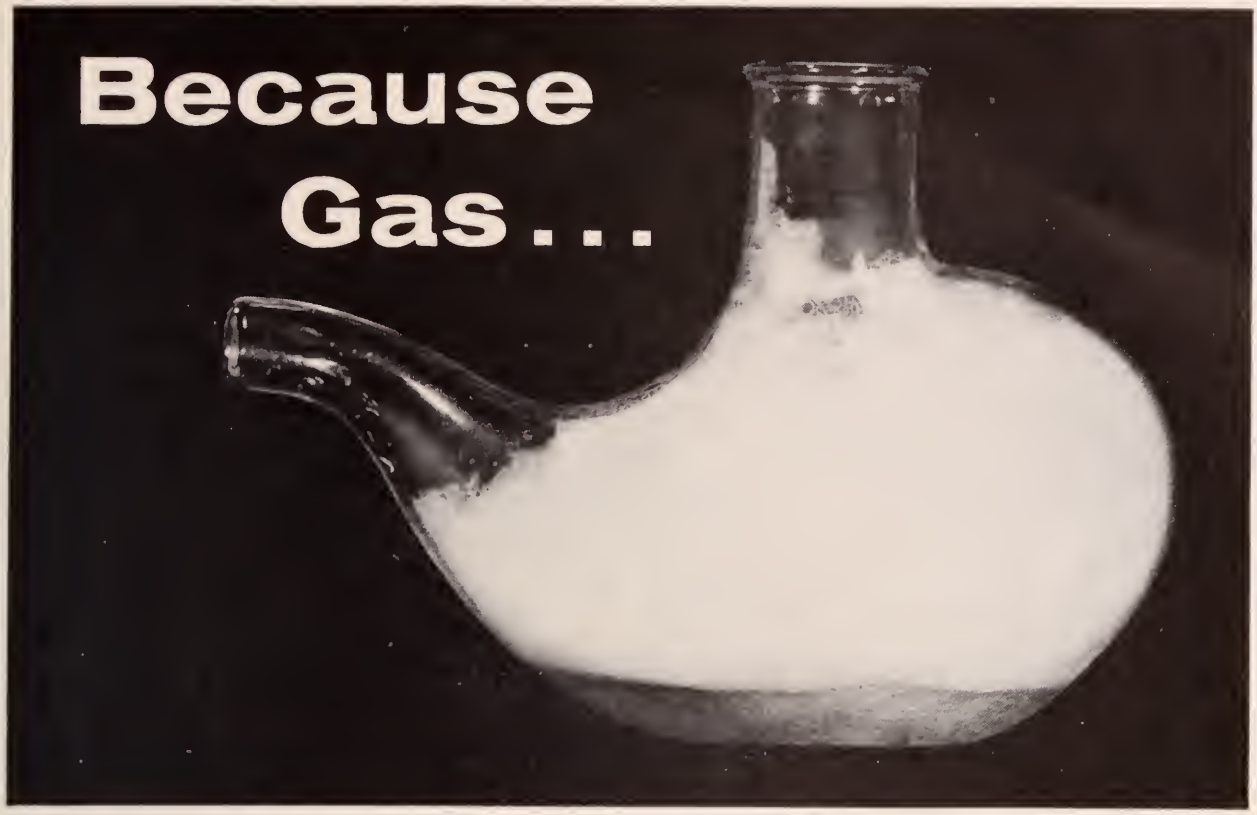
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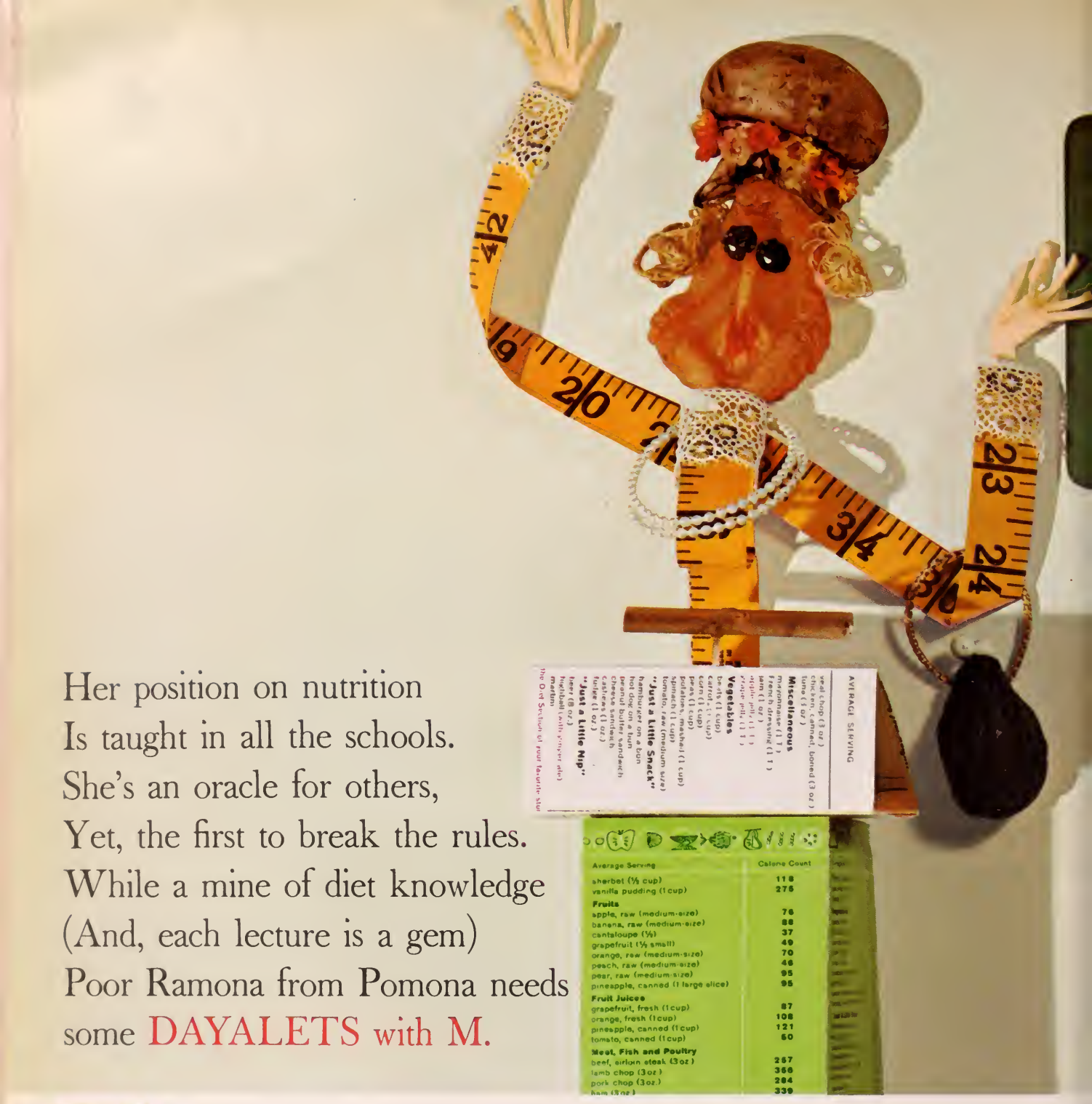
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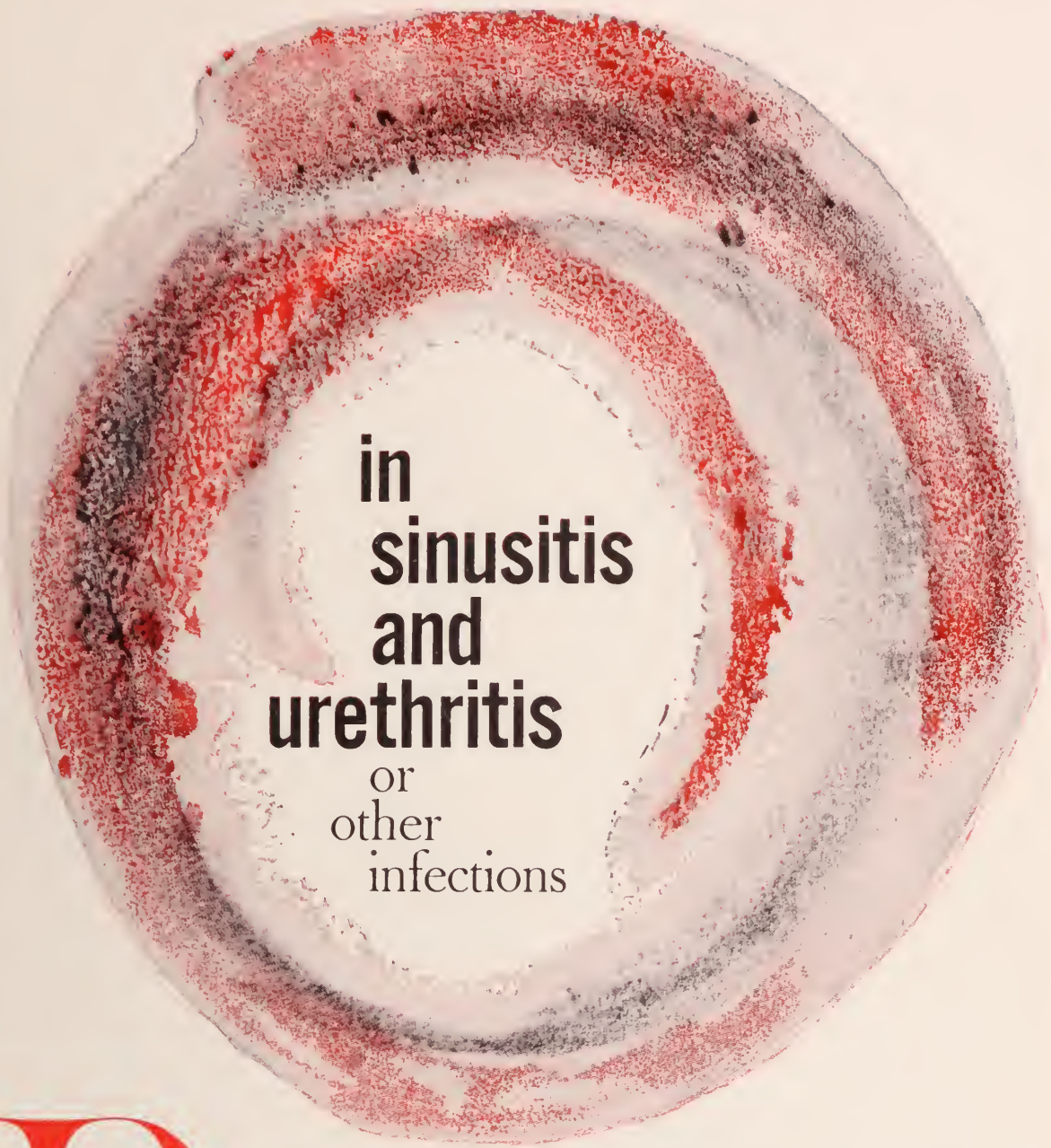


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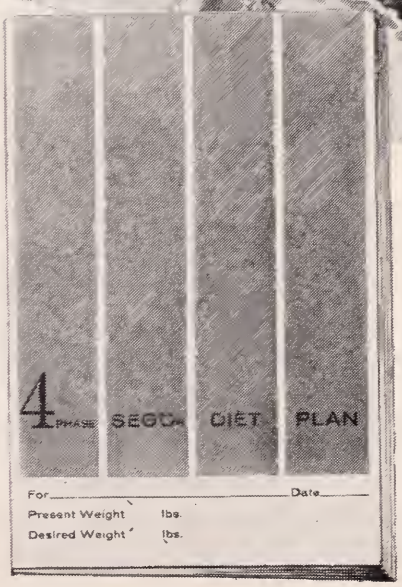
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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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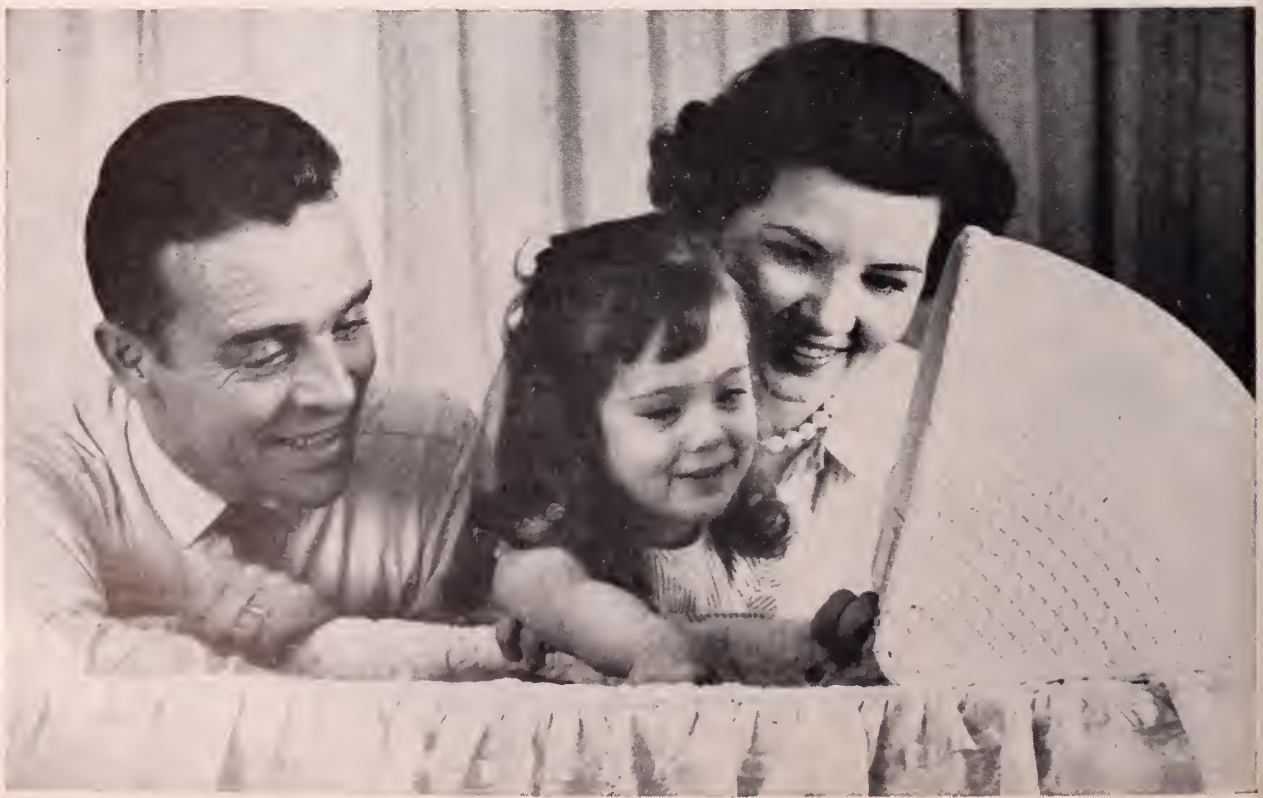
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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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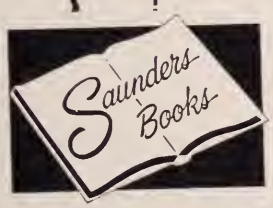
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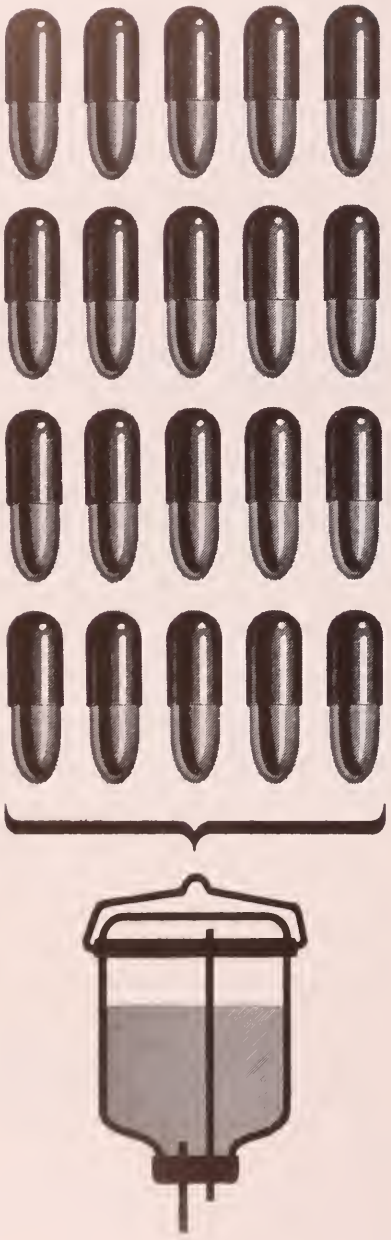
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THE JOURNAL
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Volume XLVIII, No. 6, December, 1961

Radioisotopes in Diagnosis

CHARLES A. OWEN JR., M.D.
ROCHESTER, MINN.

At the end of World War II, radioactivity meant only radium and radon to the medical profession. By 1950, radioiodine and radiophosphorus were added, the former for the diagnosis and treatment of thyroidal disease, the latter for the treatment of polycythemia vera.

The past decade has seen a remarkable increase in the medical use of radioisotopes. To some extent, this increase has been in the field of therapy—the cobalt "bomb," radiogold and chromium phosphate colloids. Mainly, however, the expansion has been along diagnostic lines.[1] Whether completely justified or not, the following procedures are practically "routine" tests today: measurement of blood volume with radioiodinated human albumin (RISA), quantitation of survival of erythrocytes with radiochromium, estimation of gastrointestinal bleeding by use of radiochromium, evaluation of pernicious anemia with radiocobalt-labeled vitamin B_{12}, assessment of hepatic function by use of radioiodinated rose bengal, evaluation of malabsorption syndromes by means of radioiodinated fat, and measurement of the thyroidal status with radioiodine.

Technical variations of some of these procedures are finding use, some of the tests may be less valuable than once thought, and newer methods are being explored. These factors will be discussed briefly.

Thyroidal Disease

RADIOIODINE UPTAKE BY THE THYROID.—Despite the accuracy of the test based on the uptake of radioiodine (I^{131}) measured six to 24 hours after an oral dose of this radioisotope,[2] about 10 per cent of mildly hyperthyroid patients are missed, as are a greater percentage of mildly hypothyroid patients. In our experience at the Mayo Clinic, the following tests, some of which depend on the pituitary-thyroid relationship, are useful.

TSH TEST.[3]—Primary myxedema may be distinguished from myxedema secondary to pituitary disease by the fact that, in the latter case, thyroidal cells exist but are not functional because of lack of stimulation by the pituitary. The test consists of measuring the uptake of I^{131} before and after an injection of commercial (bovine) thyroid-stimulating hormone (TSH, or thyrotropin). More importantly, the test can distinguish whether a patient receiving desiccated thyroid actually needs it or not. In either case, no uptake of I^{131} will be evident; after an injection of TSH, only the patients who have normally functioning thyroids will concentrate the I^{131} (fig. 1).

T_3 TEST.[4,5]—Replacement of the metabolic needs of the body with L-triiodothyronine (T_3) results in a sharp decrease in the uptake of I^{131} if the thyroid is under pituitary control but not in the case of Graves' disease. L-triiodothyronine is inexpensive, and administration of 50 micrograms a day for only three or four days is required for the test (fig. 2).

IODIDE TEST.[6]—A dose of 1 to 2 mg. of iodide (the sodium or potassium salt) will sharply reduce the uptake of I^{131} by thyrotoxic thyroids, but this dose has little effect on normal thyroids (fig. 3).

Head, Section of Biochemical Research, Mayo Clinic, and Professor of Medicine (Medical Research), Mayo Foundation, University of Minnesota Medical School.
From the Section of Biochemistry, Mayo Clinic and Mayo Foundation, Rochester, Minn.
Read before the Florida Medical Association, Eighty-Seventh Annual Meeting, Miami Beach, May 27, 1961.

ERYTHROCYTIC UPTAKE OF T_3.—This test is particularly appealing, since it is designed to evaluate thyroidal function without exposing the patient to radioactivity.[7] Instead, the patient's serum is mixed in a test tube with L-triiodothyronine labeled with I^{131}. Since patients who have high levels of protein-bound iodine (PBI) have practically saturated the thyroxine-combining capacity of their serum, most of the added hormone is free to attach to erythrocytes subsequently added to the mixture. Patients with low values for PBI can bind a large fraction of the added I^{131}-triiodothyronine to their serum, so that little of the radioactivity is transferred to the added erythrocytes. This test is so sensitive to technical variations that it has not found wide acceptance as yet.

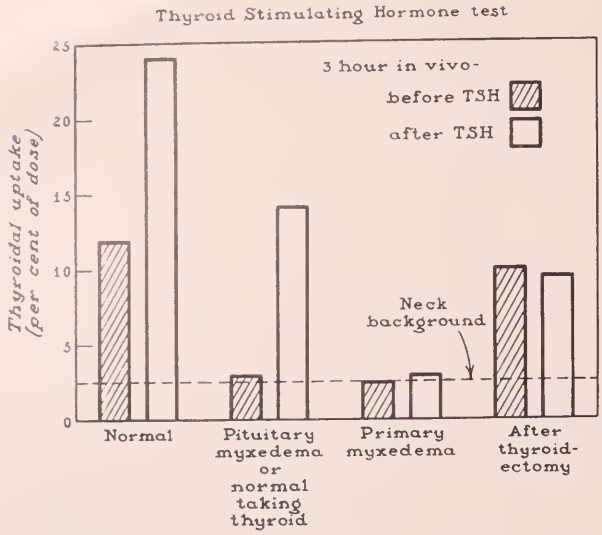


Fig. 1.—Response of thyroid to subcutaneous injections of 10 units of bovine TSH. The uptakes of I^{131} were measured three hours after oral doses of I^{131}. "Normal" persons had a normal uptake before TSH and an exaggerated response afterward, suggesting that the thyroid is not maximally stimulated by TSH under normal conditions. Patients with secondarily suppressed activity (inadequate pituitary function or administration of exogenous thyroidal hormone) had no uptake of I^{131} before and a normal uptake after TSH. Patients lacking any functional thyroidal tissue (primary myxedema) could not be stimulated by TSH. The uncommon fourth type of response apparently reflects a limited number of thyroidal cells all functioning maximally, so that no further response to TSH is possible. (Reproduced with the kind permission of the publishers from Owen.[1])

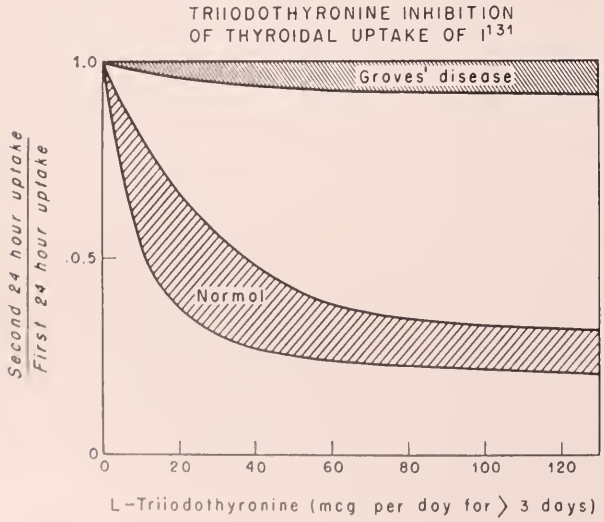


Fig. 2.—Comparison of inhibition of thyroidal uptake of I^{131} in normal persons and in patients with Graves' disease after varying doses of L-triiodothyronine given for three to five days. (Illustration drawn from data published by McConahey and Owen.[5])

BERSON'S TEST.—A straightforward test of thyroidal uptake requiring only 30 minutes has been devised.[8] A continuous record of radioactivity is made over the thyroid after the intravenous injection of I^{131}. The appearance of the curves is quite distinctive in the various states of activity of the thyroid (fig. 4); the shapes of the curves may be reduced mathematically to an expression of the rate of clearance of I^{131} from the plasma in milliliters per minute.

Hematology

ERTHROCYTIC SURVIVAL.[9]—The span of life of erythrocytes can be evaluated efficiently by the technically simple process of labeling a patient's own erythrocytes with radiochromium (Cr^{51}). It is not commonly recognized that these labeled cells may disappear from the circulation

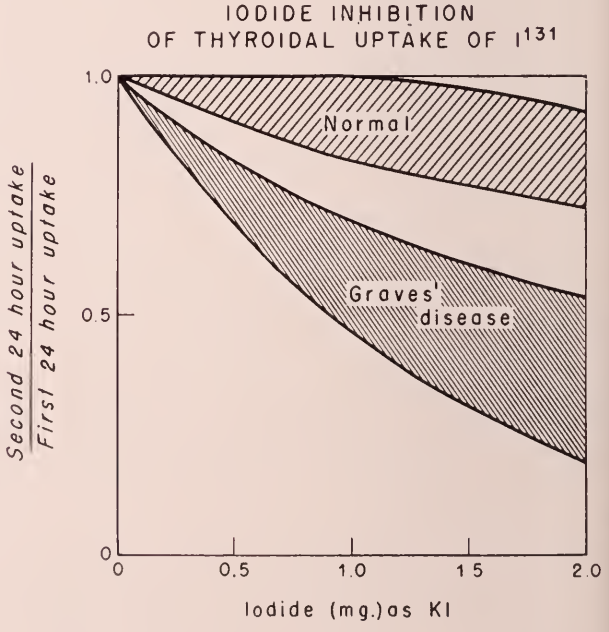


Fig. 3.—Comparison of inhibition of thyroidal uptake of I^{131} in normal persons and in patients with Graves' disease after varying oral doses of potassium iodide. (Illustration drawn from data published by Feinberg and associates.[6])

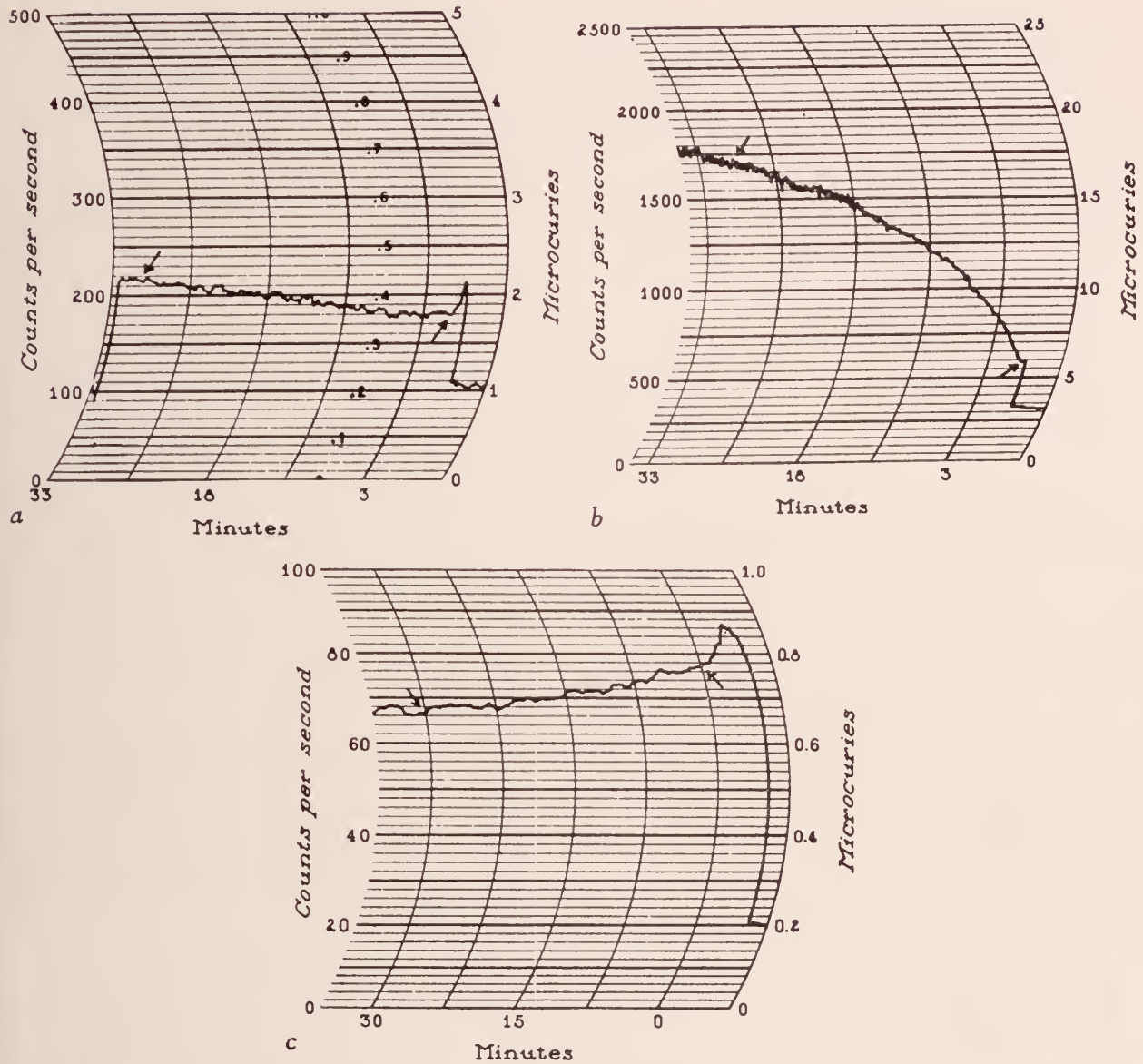


Fig. 4.—Continuous recordings (right to left) of I^{131} in thyroidal region after 25-microcurie dose given intravenously. *a.* Normal state. *b.* Hyperthyroidism. *c.* Hypothyroidism. (Reproduced with the kind permission of the publishers from Owen.[1])

by hemorrhage as well as hemolysis (fig. 5). Since a site of hemorrhage that often is overlooked is the intestinal tract, it is a wise precaution to assay stools for Cr^{51} if the circulating Cr^{51} is disappearing at too rapid a rate.

Erythrocytic Metabolism.—By differential counting, one may assess the erythrocytic survival with Cr^{51} and simultaneously evaluate erythrogenesis with radioiron (Fe^{59}). With the latter isotope, the intestinal absorption of iron may be quantitated if the iron is given orally;[10] if the isotope is given intravenously, it is possible to measure the turnover of plasmatic iron, determine the organ in which it concentrates and evaluate the efficiency of erythrocytic synthesis.

Schilling's Test.[11,12]—This test was developed to aid in the diagnosis of pernicious anemia, but it has turned out to have the added advantage of measuring defects of intestinal absorption fairly well. A dose of vitamin B_{12} labeled with radiocobalt is given orally. Two hours later, a large dose (1 mg.) of nonradioactive vitamin B_{12} is given subcutaneously; most of this is promptly excreted in the urine, carrying along about one third of any of the radioactive vitamin B_{12} that has been absorbed. Negligible radioactivity appears in the urine if the patient lacks intrinsic factor (pernicious anemia) or if he has an absorptive defect (such as sprue). These two states may be differentiated by repeating the entire test

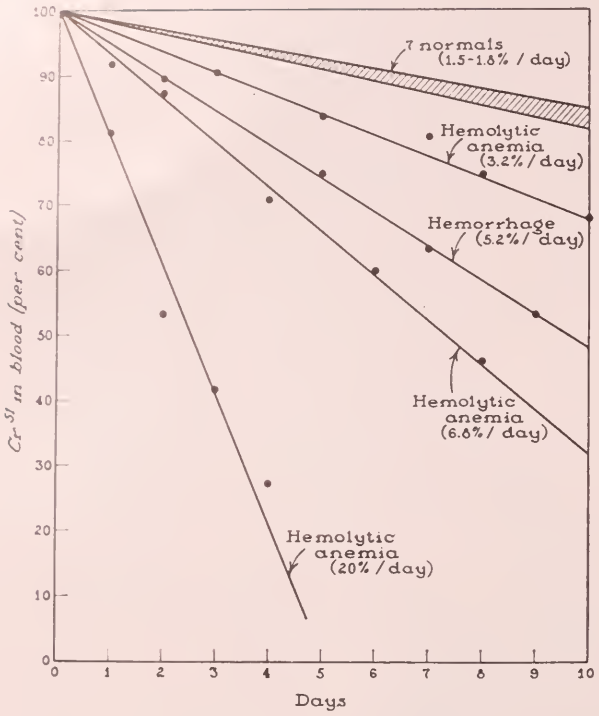


Fig. 5.—Varying rates of disappearance of Cr^{51}-labeled erythrocytes from circulation of four patients and seven controls. Note that the curve of the one patient with pronounced intestinal hemorrhage and no hemolytic component is indistinguishable from the curves of the three patients with hemolytic anemia. (Reproduced with the kind permission of the publishers from Owen.[1])

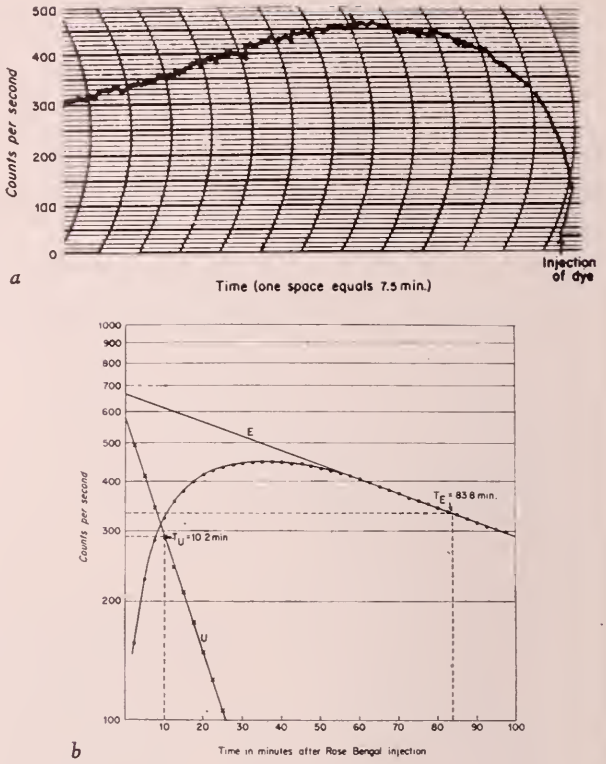


Fig. 7.—Hepatic uptake and excretion of rose bengal-I^{131} measured externally. *a.* Actual tracing (right to left) after intravenous administration of dye. *b.* Tracing reproduced (left to right) on semilogarithmic paper, with calculations of hepatic uptake (T_U) and excretion (T_E). In this case, the dye was concentrated by the liver at a rate of 6.8 per cent per minute and excreted at a rate of 0.8 per cent per minute. (Reproduced with the kind permission of the publishers from Moertel and Owen.[14])

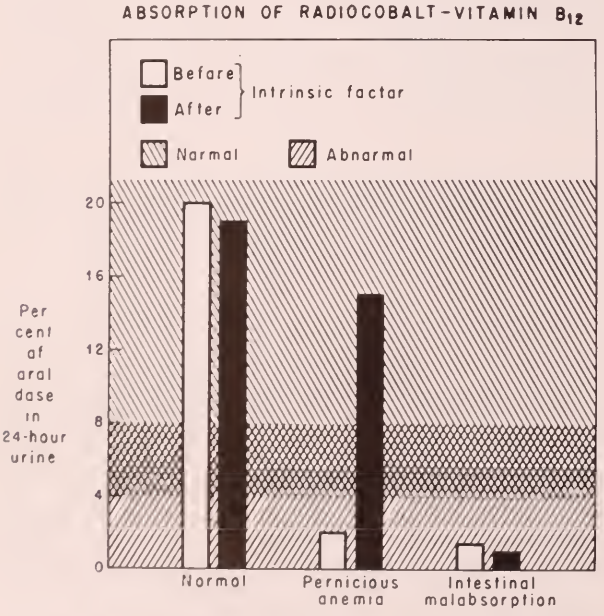


Fig. 6.—Schilling's test. This shows the urinary excretion of radiocobalt in a normal person, one with pernicious anemia and one with sprue after an oral dose of radioactive vitamin B_{12}. The normal person did not respond to added intrinsic factor because absorption of vitamin B_{12} was already maximal; the patient with sprue was unable to absorb the vitamin despite the presence of intrinsic factor; the response of the patient with pernicious anemia is entirely characteristic. (Illustration drawn from data published by Bull and associates.[12])

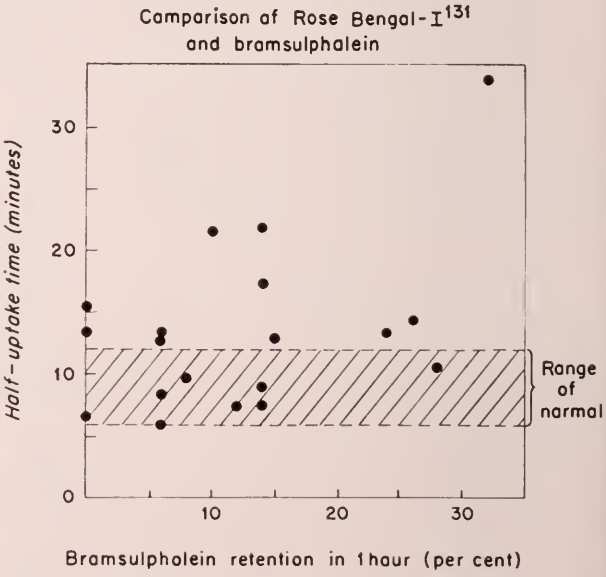


Fig. 8.—Comparison of BSP test (retention of BSP in blood one hour after dose of 5 mg. per kilogram of body weight) with hepatic uptake (T_U) of radioiodinated rose bengal (see figure 7). Two patients had abnormal values for rose bengal but normal levels of BSP. On the other hand, seven patients, all with abnormal retention of BSP, exhibited normal results with the rose bengal technic. (Reproduced with the kind permission of the publishers from Moertel and Owen.[14])

with the addition of a commercial preparation of intrinsic factor (fig. 6).

Gastroenterology

Two tests employing radioisotopes in the field of gastroenterology have been promoted extensively and accepted fairly widely. After a second look, neither appears to live up to expectations.

I^{131}-Rose Bengal Test of Hepatic Function.[13]—The labeling of rose bengal with I^{131} has made it possible to measure "in vivo" the rate of extraction of the dye by the liver from the blood and the rate of excretion of the dye into the biliary system (fig. 7). By arithmetic manipulation, one can even derive the volume of blood in the liver. Despite these apparent advantages, a carefully controlled study[14] suggested that the classic test employing sulfobromophthalein (BSP) is more precise in the evaluation of hepatic function in nonjaundiced patients (fig. 8).

I^{131}-Triolein Test of Pancreatic and Intestinal Function.[15]—If pancreatic enzymes are lacking in the intestine, fats are poorly absorbed because they cannot be reduced to free fatty acids. Neither free fatty acids nor fats are absorbed well in various malabsorption syndromes. The use of a fat such as triolein labeled with I^{131} appeared to offer an easy technic for evaluating intestinal disease; if it is not absorbed but if labeled oleic acid is, then pancreatic disease is suggested; if neither the fatty acid nor the fat can be absorbed, then the fault apparently lies with the intestine. Unfortunately, the sensitivity of the triolein test is considerably less than that of the quantitative evaluation of stool fats, and this method must be considered useful only if the physician does not have access to an adequate chemistry laboratory[16] (fig. 9).

Localization of Tumors

Despite much effort and many ingenious approaches, the localization of tumors by radioisotopic means has met with only limited success. Supratentorial tumors may be visualized by scanning the head after administration of I^{131}-labeled fluorescein or albumin, or by iodide^{131} itself; more spectacular results have followed use of the positron-emitting isotopes of copper and arsenic. The real clinical problem, however, lies in tumors below the tentorium, and here the isotopic tests have been uniformly unsatisfactory.

Radiophosphorus (P^{32}) does concentrate well in most tumors, as well as in all rapidly growing

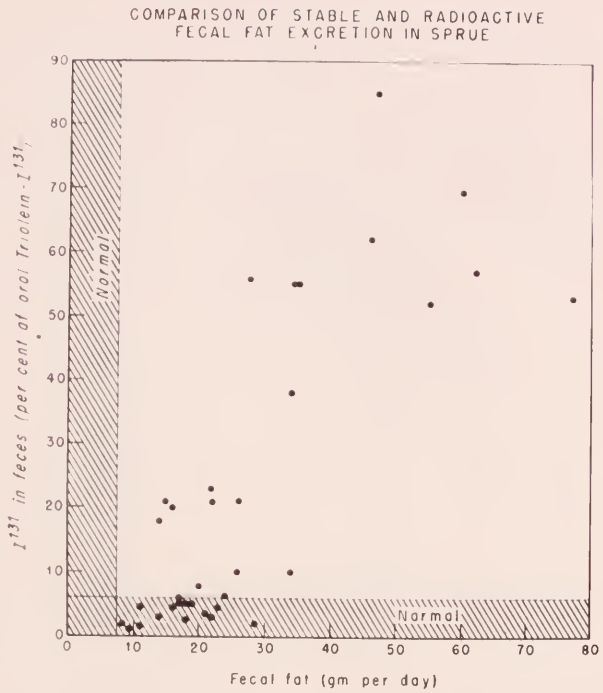


Fig. 9.—Comparison of fecal fat with fecal excretion of I^{131} after oral dose of radioiodinated triolein. The radioactive technic is insensitive in the region of mild steatorrhea (less than 30 Gm. of fat excreted per day). (Illustration drawn from unpublished data of Moertel and co-workers.[16])

tissues, but its beta rays are so weak that only a few millimeters of tissue damp the radioactivity. External counting can be used only for extremely superficial tumors, and most investigators find results of the test with P^{32} clearly positive only when the tumor is clinically obvious. One exception to this pessimistic picture is the use of P^{32} to distinguish nonmalignant retinal detachment from malignant tumors of the eye. Since small Geiger counters can be pressed snugly against the eyeball, the increased uptake by malignant tumors can be quantitated.

Localization of metastatic lesions secondary to carcinoma of the thyroid is often possible because of the penetrating gamma rays of I^{131}. While the presence of metastasis may be suspected by carefully surveying the body with a hand-held radiation detector, scintiscanning technics add to the precision (and expense) (fig. 10).

Urology

I^{131}-Hippuran Renography.[17]—This is one of the newer diagnostic radioisotopic technics, and it holds promise as a useful method for studying renal function and also ruling out renal disease in patients with hypertension. The principle of the test depends on the fact that sodium iodohippurate (Hippuran) is extracted from the blood by the

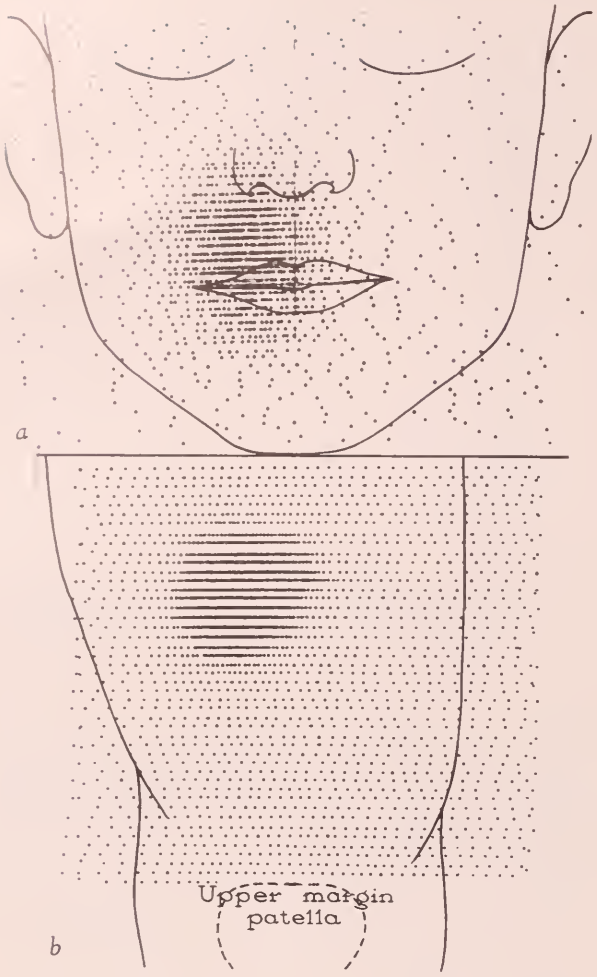


Fig. 10.—Recordings ("scintiscans") of I^{131} localization in metastatic tumors from thyroidal carcinoma. *a*. Metastasis to tonsillar region. *b*. Metastasis to femur. (Reproduced with the kind permission of the publishers from Owen.[1])

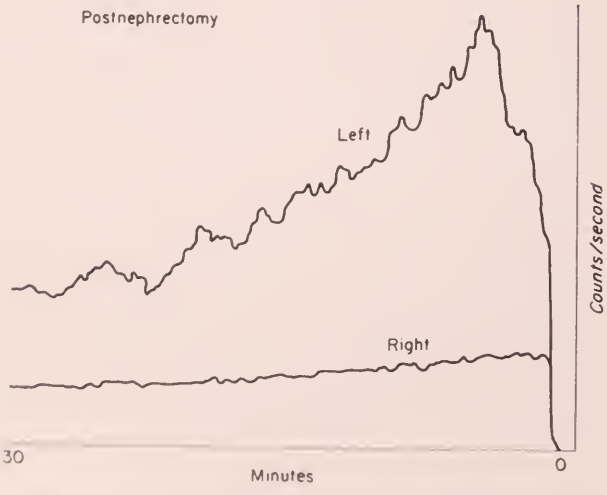


Fig. 11.—Radioactivity over renal regions of back recorded simultaneously by two matched radiation detectors after intravenous administration of I^{131}-Hippuran. The tracings (right to left) show no activity on the right (postnephrectomy) and a hypernormal ("compensatory") uptake on the left. Radioactivity in the kidney decreased as the dye was excreted into the urine. (Data kindly furnished by Dr. W. N. Tauxe, Section of Clinical Pathology.)

kidney and is then secreted into the urine (like the extraction of rose bengal by the liver). The amount of radioactive Hippuran may be measured externally and, if paired counters are used, the function of each kidney may be compared directly (fig. 11). It is likely that the test employing radioactive Hippuran will displace the similar test using radioactive iodopyracet (Diodrast),[18] which is cleared by the liver as well as by the kidneys.

Metabolism of Electrolytes

Since pathologic states involving the heart, liver, kidneys or adrenals may be accompanied by disordered metabolism of water and electrolytes, methods for measuring body water, the intracellular and extracellular spaces, and the distribution of sodium and potassium have been studied extensively. Technics are currently available for measuring body water (with heavy water [D_2O] or radioactive water [$H_2{}^3O$]), body potassium (with K^{42}) and body sodium (with Na^{22} or Na^{24}). None of these technics are ideal, since the measurement of the isotope is complex (deuterium, tritium) or the half-lives are too short (Na^{24} = 15 hours, K^{42} = 12½ hours) or too long (Na^{22} = 2½ years). The availability of more satisfactory isotopes or of simpler methods for their measurement could make these tests extremely useful.

As an aside, one of the few natural radioisotopes present in the body in amounts sufficient to be measured is radiopotassium (K^{40}), which has a half-life of more than 1,000,000,000 years. The body content of potassium can be assessed accurately by an elaborate "whole-body counter," but few of these expensive devices exist.

Conclusion

New radioisotopic tests will be proposed at an increasing rate. Some will prove to be useful and will find their way into the radioisotopic laboratory. Others will be impractical or insensitive or even dangerous radiationwise. To discount all new methods because radioisotopes "are a fad," or to accept uncritically every new proposal, will only retard progress.

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Newer Methods for the Detection of Congenital Cardiac Shunts

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H. Coleman Kramer, M.D., Leonard M. Silverman, M.D.
MIAMI BEACH

Standard techniques for the diagnosis of congenital intracardiac and extracardiac shunts have focused on detection of changes in oxygen content in the right heart and pulmonary artery for left to right shunts, and on the detection of systemic arterial oxygen unsaturation for the detection of right to left shunts. Localization of the site of right to left shunting by the oxygen technique has been notoriously poor and based upon inferential circumstantial evidence.

Dissatisfaction has also been expressed with the oxygen method for determination and localization of left to right shunts. Small shunts, up to perhaps 20 per cent of total flow, may readily be missed, since an oxygen stepup in the right atrium of at least 2 volumes per cent as compared to the superior and inferior vena cava is required to diagnose an interatrial septal defect. Increments of 1 and 0.5 volume per cent in the right ventricle and pulmonary artery respectively are required for the diagnosis of an interventricular septal defect and patent ductus arteriosus respectively. The differential diagnosis of interatrial septal defect and anomalous pulmonary venous drainage is virtually impossible by the oxygen content technique unless the catheter tip is passed into the pulmonary vein. Even then radiographic differentiation is often difficult between direct entrance of the tip into the pulmonary vein from the right atrium and indirect entrance from the left atrium, after passage of the tip through an interatrial defect.

The introduction of the indicator dilution technique into diagnostic studies in congenital heart disease has been a great step forward. In our laboratory the oxygen technique has virtually been discarded in favor of the dye dilution technique employing indocyanine green. In actual practice this dye can be used freely to inscribe as

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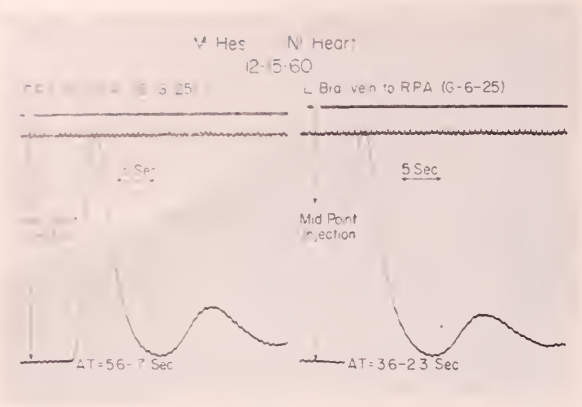


Figure 1

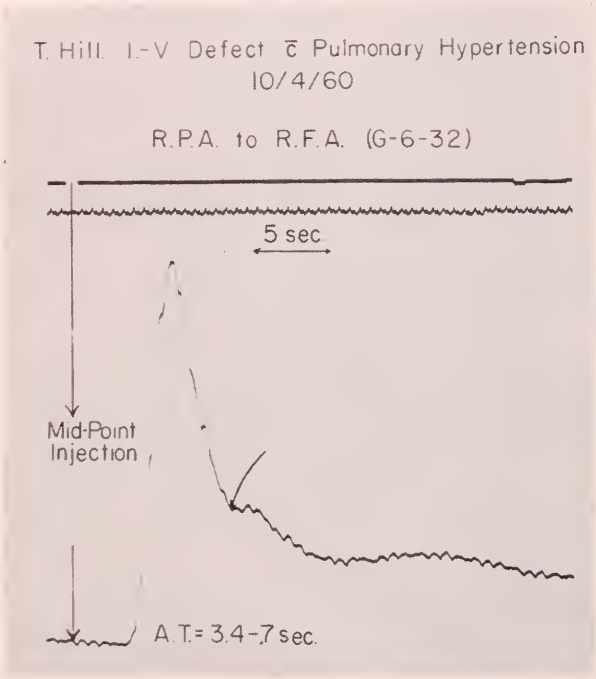


Figure 2a

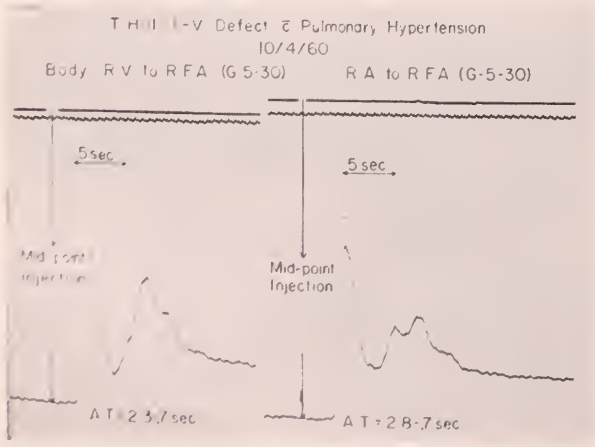


Figure 2b

many curves as desired. We have employed total doses of 2-4 mg./Kg. without any reaction. This dosage level has permitted inscription of up to 25 curves per patient. Good dye curves can be obtained with as little as 3 mg. per curve in the adult. Since indocyanine green has its maximum absorption point at 800 MU, dye dilution curves can be obtained from within the right heart chambers as well as from systemic arteries. At 800 MU the transmission of light by oxygenated and reduced hemoglobin is similar and variations in oxygen saturation do not distort the recorded dilution curve as is the case when Evans Blue (maximum absorption point 625 MU) is employed. The sites of dye injection and dye curve inscription may thus be varied at will.

Indicator Dilution Technique

Normal dye dilution curves are shown in figure 1. To the left, dye has been injected into the right pulmonary artery and a curve inscribed from the right femoral artery. To the right the injection site is the left brachial vein and the inscription site the right pulmonary artery. The appearance time (interval from the mid-point of the injection period to the appearance of dye) is 5.6-0.7 sec. for the former curve. The 0.7 sec. correction is for the dead space of the sampling system. The longer 2.3 sec. correction time for the latter curve is due to the 100 cm. length of the cardiac catheter. The characteristics of the normal curve are readily discernible. There is an initial rapid upstroke and a rapid downstroke reaching nearly to the base line. The recirculation curve is readily seen.

Two abnormal types of dye dilution patterns may develop as a result of cardiac shunts. If a left to right shunt is present, a portion of the left atrial or left ventricular or aortic blood (and dye) passes directly to the periphery and a portion recirculates through the lung and reaches the periphery later than it ordinarily would. As a result the downstroke of the curve is interrupted (arrow, fig. 2a). The total height or amplitude of the curve is also decreased. The appearance time is normal for the individual patient, as in figure 2a, a young boy with an Eisenmenger complex. The injection site is the right pulmonary artery and the sampling site the femoral artery.

If a right to left shunt is present (fig. 2b), part of the right heart blood (and dye) passes through the lung to the left heart and periphery. Another portion of the right heart blood, however, passes directly to the periphery, bypassing the

lungs. As a result the appearance time is shortened and a double-humped curve results (fig. 2b). The injection sites are the body of the right ventricle and the right atrium. The appearance time is shorter from the right ventricle (fig. 2b) than from the pulmonary artery (fig. 2a); this is the reverse of the normal appearance time relationship. The appearance of a double-humped curve from the right ventricle but not from the pulmonary artery localizes the source of the right to left shunt to the right ventricle. If a double-humped curve appeared from the right atrium but not the right ventricle, the site of the right to left shunt would of course be the right atrium.

Localization of the right to left shunt in a patient with patent ductus arteriosus with pulmonary hypertension and reversal of the shunt is illustrated in figure 3. Dye injection into the distal left pulmonary artery with simultaneous sampling from the right femoral and brachial arteries reveals relatively normal curves (fig. 3a). On the other hand, dye injection into the main pulmonary artery with sampling from the same two systemic arteries reveals a shortened appearance time from the femoral but not the brachial artery (fig. 3b). The former curve is also double-humped, indicating a right to left shunt to the femoral but not the right brachial artery. The diagnosis of patent ductus arteriosus with reversal of the shunt is thus established.

Interruption of the downstroke of a systemic arterial dye curve (fig. 2a) establishes the diag-

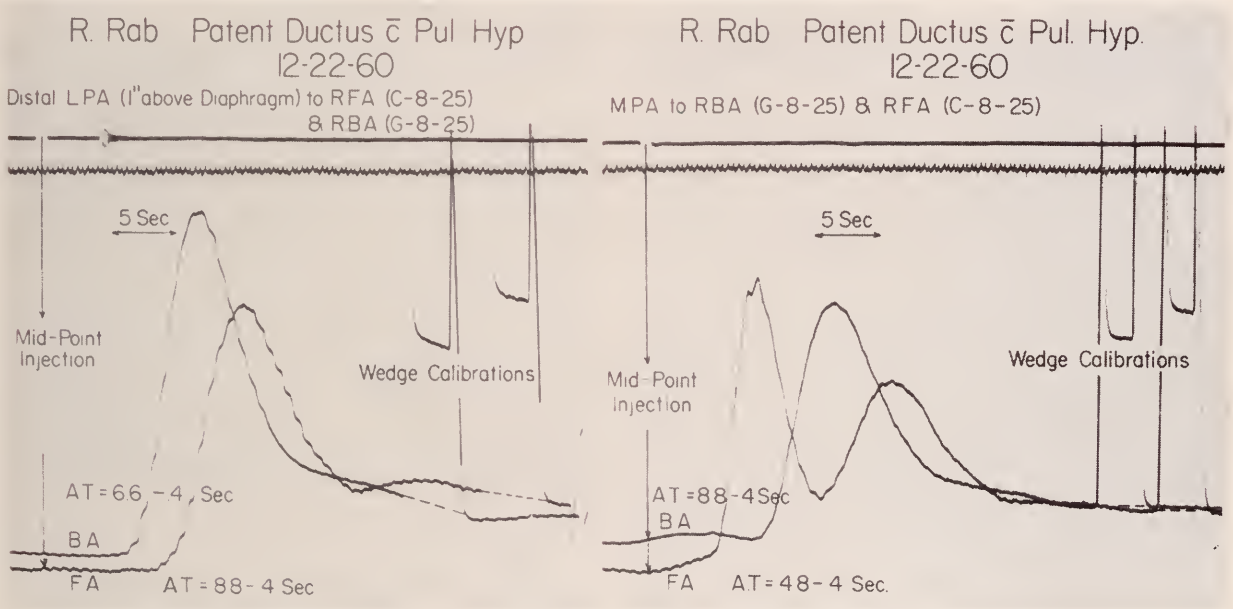


Figure 3

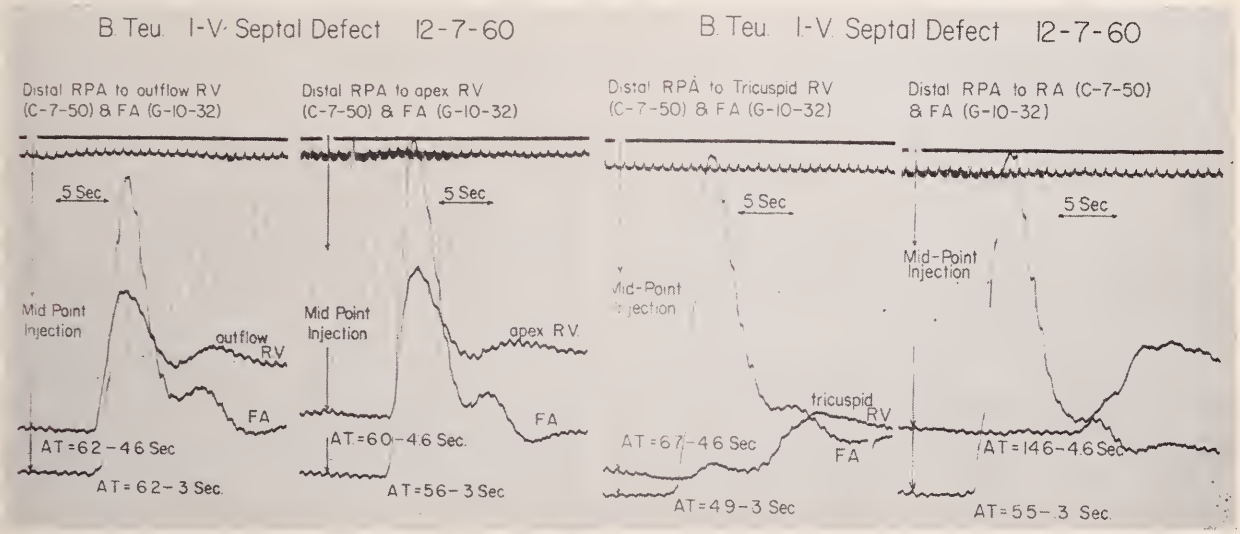


Figure 4

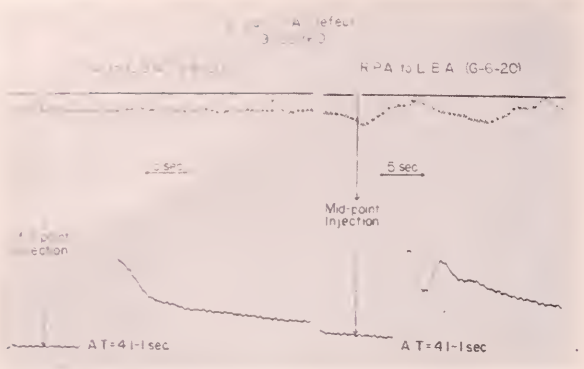


Figure 5a

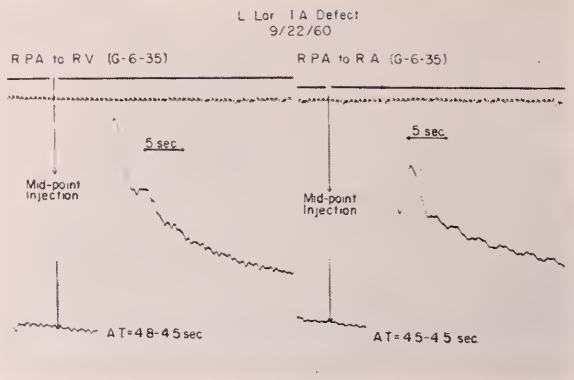


Figure 5d

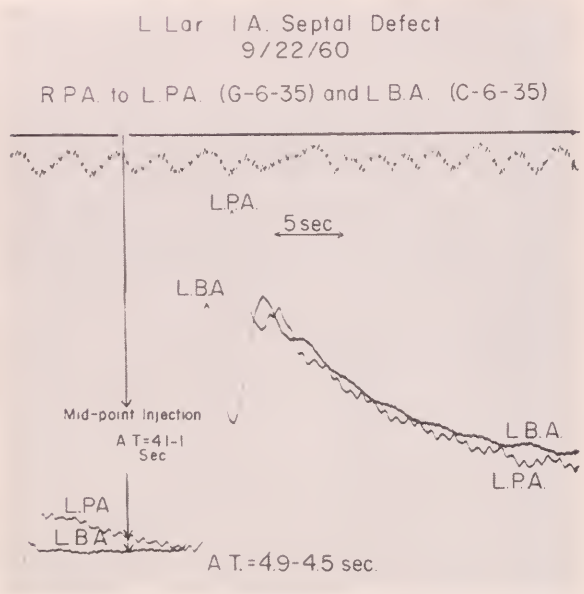


Figure 5b

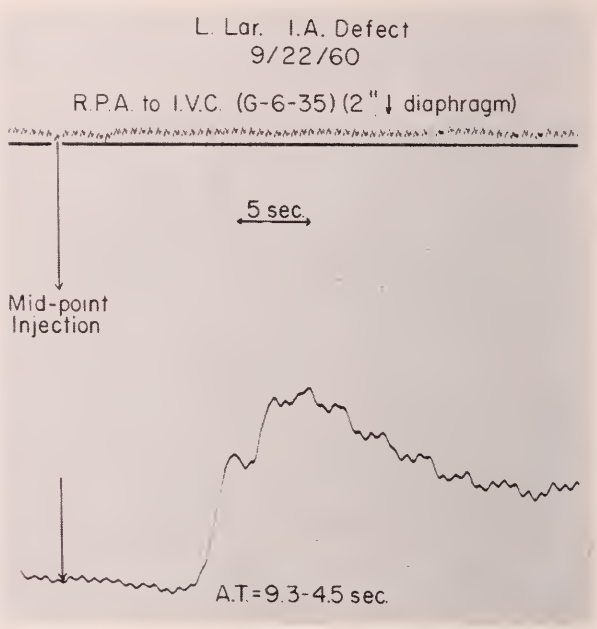


Figure 5e

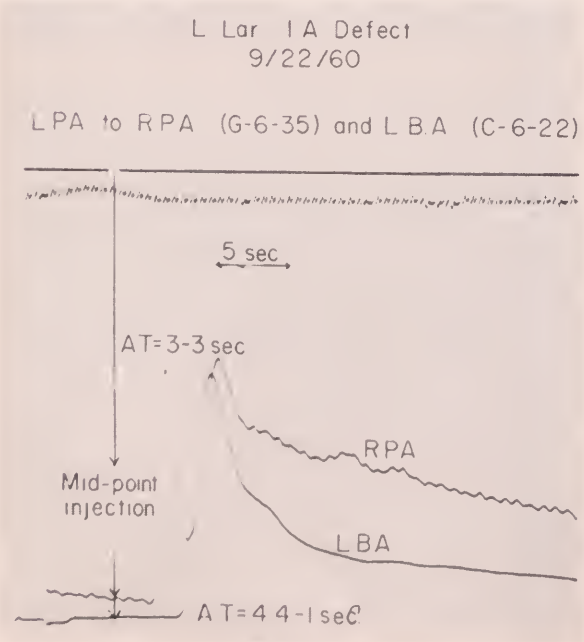


Figure 5c

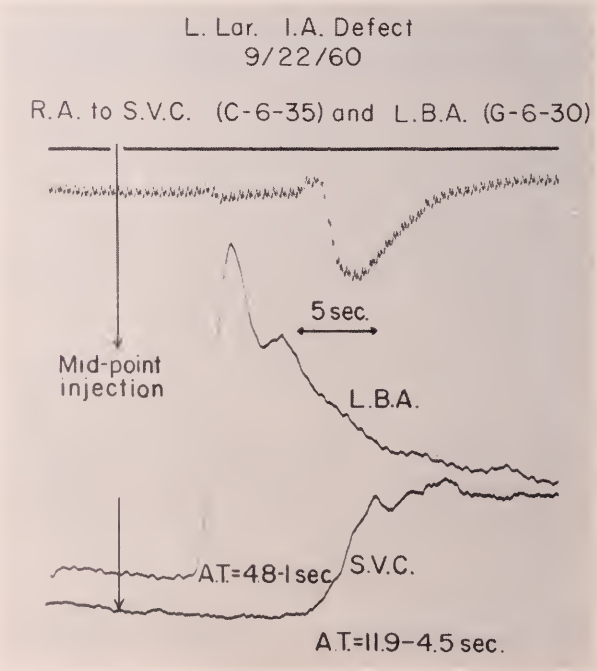


Figure 5f

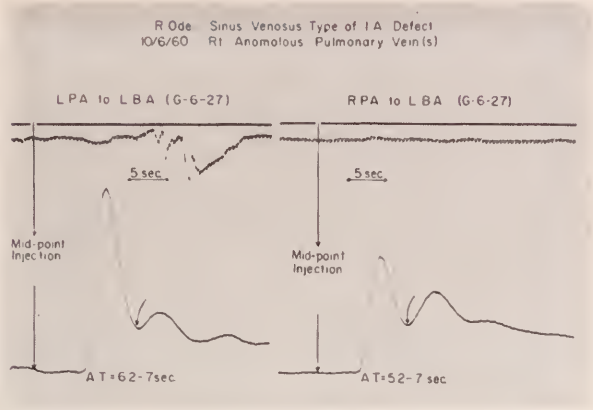


Figure 6a

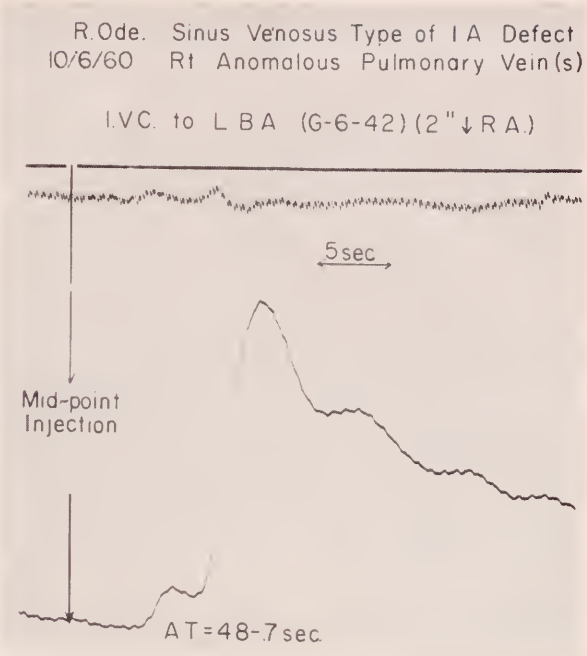


Figure 6b

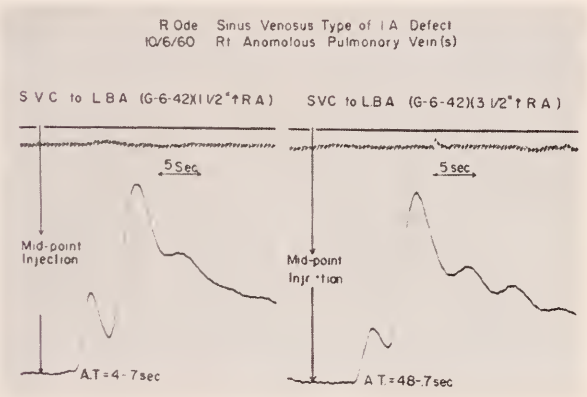


Figure 6c

nosis but not the localization of a left to right shunt. Exact localization is readily performed by simultaneous inscription of a systemic arterial curve and of a series of right heart curves (fig. 4). In figure 4a dye injection has been made into the right pulmonary artery; simultaneous dilution curves have been inscribed from the femoral artery and two sites in the right ventricle. In the absence of a left to right interventricular shunt, the appearance time for dye in the right ventricle should be at least 8-12 sec. since dye must traverse the pulmonary circulation, left heart, systemic circulation and right heart before appearing in the right ventricle. The right ventricular appearance time of 1.4 to 1.6 sec. after distal right pulmonary artery injection is diagnostic of a left to right shunt at or upstream to the sampling site. Both femoral artery inscription curves demonstrate obvious interruption of the downstroke. In figure 4b final localization of the

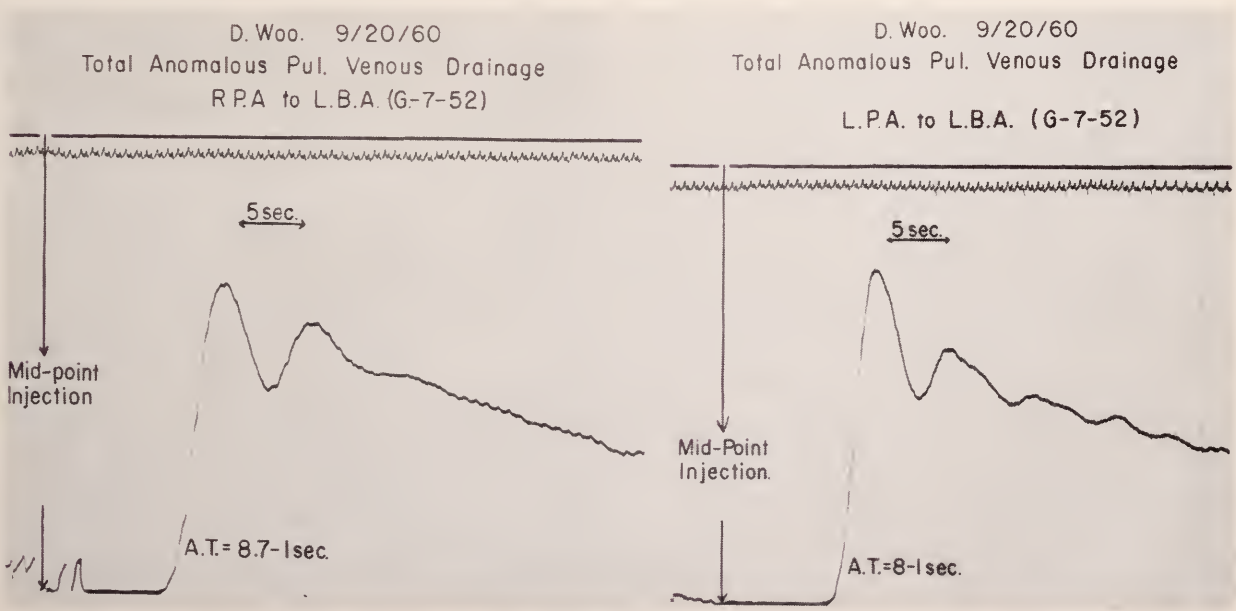


Figure 7a, b

one of the left to right shunt is made. The appearance time in the tricuspid area of the right ventricle is 2.1 sec.; the corresponding appearance time in the right atrium is 10 sec. The site of the left to right shunt is thus the right ventricle.

Localization of an interatrial shunt plus the demonstration of a differential shunting from the right (as compared to the left) lung across the interatrial defect is demonstrated in figures 5a-f. The anatomic substrate for preferential right lung shunting across an ostium secundum type of interatrial defect has been well established at cardiac surgery by the observation that the openings of the right pulmonary veins into the left atrium are much closer to the ostium secundum defect than are the openings of the left pulmonary veins. In

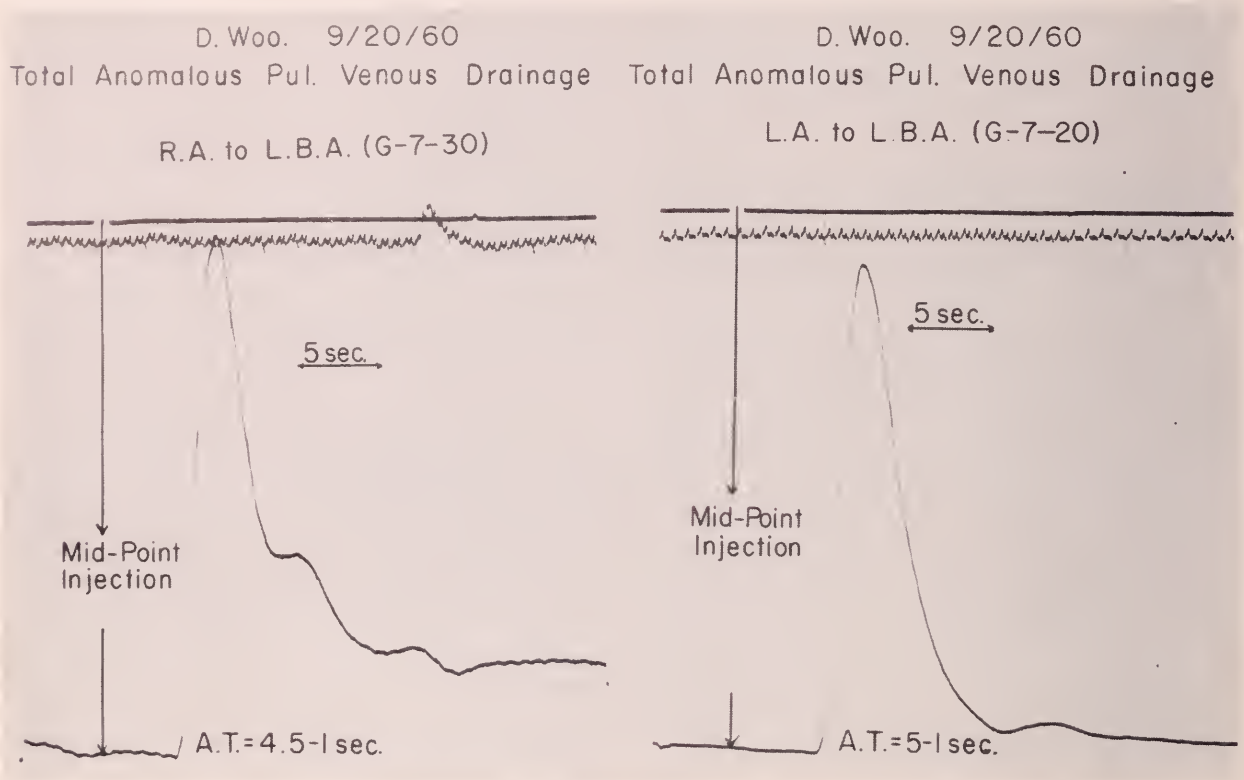


Figure 7c, d

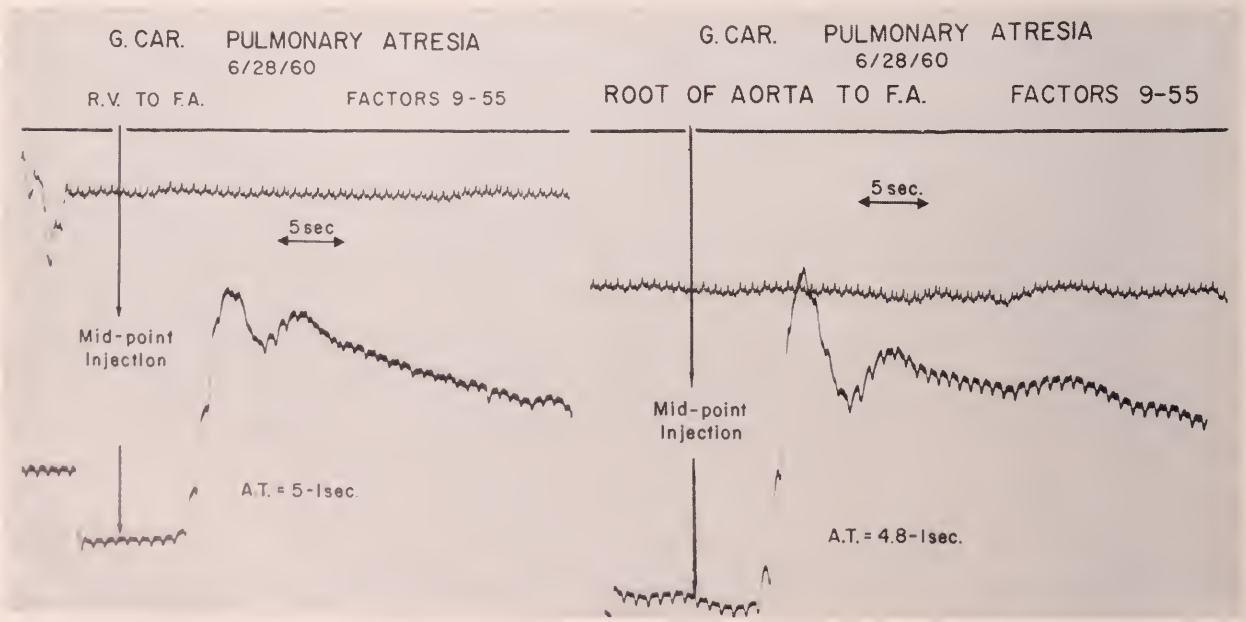


Figure 8a, b

Figs. 1-8—See text for detailed explanations of the dye dilution curves.

figure 5a the height of the brachial artery curve after dye injection into the left pulmonary artery is greater than after right pulmonary artery injection; the interruption of the downstroke is also considerably more prominent on the latter curve. Both of these findings are compatible with preferential left to right shunting from the right lung. These findings are demonstrated in another manner in figures 5b and 5c. In figure 5b, dye is injected into the right pulmonary artery and sampled from the left pulmonary and brachial arteries; in figure 5c the sites of injection and sampling are reversed. In the former curve the height of the left pulmonary artery curve (indicative of the degree of left to right shunting) is greater than that of the brachial artery; in figure 5c the heights of the pulmonary artery curve and brachial artery curve are equal despite the fact that the sensitivity of the brachial artery curve is less in figure 5c than in figure 5b. The early appearance time of dye in one pulmonary artery after injection into the other pulmonary artery is of course indicative of a left to right shunt. In figure 5d early appearance time is also present in the right atrium and ventricle. The absence of an early appearance time in the inferior vena cava (after right pulmonary artery injection, fig. 5e) and in the superior vena cava (after right atrial injection, fig. 5f) is diagnostic of an interatrial septal defect. At surgery an ostium secundum defect without anomalous pulmonary venous connection was found.

Preferential right lung shunting was also noted in another patient (fig. 6a-c). In figure 6a the difference in the brachial artery curve after injection into the two pulmonary arteries is shown. The greater degree of left to right shunting from the right pulmonary artery is readily noted. In figure 6b dye has been injected into the inferior vena cava and aspirated from the left brachial artery. A small right to left shunt is evident as part of a double-humped curve. Such small right to left shunts after inferior vena caval injection are not infrequently seen in the ostium secundum type of interatrial defect. A right to left shunt, however, after superior vena caval injection is not usually seen in this type of interatrial defect. Such a shunt is evident in figure 6c. These findings are highly suggestive, on the other hand, of a sinus venosus type of interatrial defect with anomalous connection of a right pulmonary vein into the superior vena cava or the right atrium.

The data in a patient with total anomalous pulmonary venous drainage are shown in figure 7. The brachial artery curve is similar after right or left pulmonary artery injection (fig. 7a,b). Since all pulmonary veins eventually empty into the right atrium, and in turn the right atrium empties into both the right ventricle and left atrium (via the interatrial defect which is necessary for survival in total anomalous pulmonary venous drainage), the drainage pathways of the two atria would be expected to be similar. Figure 7c,d demonstrate the similarity in brachial artery dye dilution curves after injection into the right or left atrium.

Another useful application of indicator dilution curves is illustrated in figure 8a,b. During cardiac catheterization the catheter tip repeatedly passed into a high pressure artery, the ascending aorta. The pulmonary artery could not be identified. Dye dilution curves from the ascending aorta and right ventricle are identical indicating that the drainage pathway for blood in the right ventricle is entirely into the aorta. Pulmonary atresia was subsequently verified anatomically.

Summary

It has become evident that measurement of oxygen content in the various chambers of the right heart and systemic arteries is not adequate for modern definitive diagnostic studies in congenital heart disease. The value of indicator dilution curves employing indocyanine green is illustrated in several varieties of congenital cardiac lesions.

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Management of Respiratory and Intestinal Infections in Children

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Despite the advancements in chemotherapy during the past 30 years, respiratory and intestinal infections persist as the most common disorders in children, being responsible for approximately 38 per cent of the diseases treated by pediatricians in the United States.[1] Since the immaturity of the enzymic systems and metabolic functions in infants and young children facilitates the rapid dissemination of such infections into other organs and systems, even the mildest of these can give rise to serious complications if not adequately managed.[2,3] In mild infections, therapy is best limited to symptomatic relief and prevention of complications, but the presence of any deep-rooted viral or bacterial infection demands systemic therapy.[3,4]

The choice of a proper antibacterial agent for children presents certain difficulties.[2,3] The indiscriminate use of the antibiotics has led to the development of highly resistant pathogenic mutants as well as to patient sensitization. Thus, the infecting pathogens must be isolated, their resistance to the available antibiotic measured, and any sensitivity on the part of the patient established.[5, 6] The time involved in carrying out these determinations is a further complication, particularly in the treatment of children. Once an agent has been selected, there remains the possibility of the child's intolerance to therapeutically effective dosages and of inability to detoxify and eliminate the drug.[2, 3] Also, the frequent use of a tolerated antibiotic in a child, particularly in minor infections, may induce sensitivity to the drug, negating its future use in the patient even when it is the drug of choice.

An alternative to a potentially dangerous or sensitizing antibiotic is a sulfonamide. Through increased knowledge of the biochemical and physiologic actions of the different sulfonamides, many of their less popular features have been eliminated. Their toxicity potentials have been reduced, and their range of clinical application has been expanded through the development of long-acting derivatives ideally suited for use in systemic infections.[7,8]

Among the improved sulfonamides is Madribon.* Since its introduction in 1959, it has been extensively used in the management of respiratory, urogenital and gastrointestinal infections, as well as in primary and secondary pyogenic infections of the integument.[9-14] It is a potent, easily absorbed agent with long-sustained action and a highly flexible dosage schedule. It can be administered in tablets, capsules, suspension, or pediatric drops, and is considerably more economical than the standard antibiotics.

In the present study Madribon was used in a series of children with systemic infections, regardless of the in vitro sensitivity response of the isolated pathogens.

Materials and Methods

Forty-eight children seen in private practice were treated with Madribon for respiratory and intestinal infections. They ranged in age from five months to 11 years, with approximately equal distribution among males and females. The diagnostic categories, in their order of frequency, were tonsillitis, otitis media, tonsillitis with associated catarrhal and serous otitis media, pharyngitis, bronchitis, sinusitis, enterocolitis, and rhinitis. These were accompanied by headache, dry and painful throat, upset stomach, fever, referred earache, and general malaise.

Bacteriologic cultures were taken of 39 of these patients and tested for in vitro sensitivity to Madribon. A total of seven organisms was isolated; these included α-streptococci in 18 cultures, β-streptococci in nine, hemolytic Staphylococcus aureus in eight, Escherichia coli in four, Diplococcus pneumoniae in three, Candida albicans in one and Sarcina lutea in one. These occurred alone or in combinations of two and three organisms.

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*Trademark of Hoffmann-La Roche for sulfadimethoxine, Hoffmann-La Roche Inc., Nutley, N. J.

Madribon was administered in tablets and suspension. The usual tablet dosages were 1 Gm. initially, followed by 0.5 Gm. daily, but the more seriously ill children were given doses as high as 2 Gm. initially, with maintenance doses of 1 Gm. per day. When the suspension was used, the initial dose was 2 drams, followed by 1 dram daily, except in children one year old and younger who received ¾ to 1 dram initially with maintenance doses of ½ dram per day. Therapy was continued for from one week to four weeks, with an average of two weeks.

The only adjunctive medications used were nasal drops and a throat spray in two children and Otodyne ear drops for the relief of pain in another. The usual precautions in sulfonamide therapy were also observed.

Results

The response to Madribon therapy was excellent in 24 children, good in six, and poor in 13, with no follow-up in five (table 1). The bacteriological cultures revealed that eight patients had pathogens resistant in vitro to the sulfonamide. Judged by the clinical responses, however, four of these were cured, and one was greatly improved.

Table 1. — Results of Therapy With Madribon

Diagnoses	No. of Patients	Results			
		Excellent	Good	In-Effective	No Follow-up
Tonsillitis	17	8	1	5	3
Otitis media	12	7	1	3	1
Tonsillitis and otitis media	8	4	0	4	0
Pharyngitis	4	2	2	0	0
Bronchitis	2	1	0	0	1
Sinusitis	2	1	1	0	0
Enterocolitis	2	0	1	1	0
Rhinitis	1	1	0	0	0
Total	48	24	6	13	5

Many of the children with excellent results showed dramatic response to Madribon with rapid relief of their symptoms as well as eradication of the foci of infection. One child in this group later had a relapse and was referred for surgical treatment. This relapse occurred three months after cessation of Madribon therapy and could hardly be attributed to ineffectiveness of the drug.

Those with good results also obtained ultimate cures, but not as quickly. One child had an initially rapid clearing of his infection followed by relapse a few days later. With a renewal of Madribon therapy there was a complete remission of the infection, but as a measure of safety therapy was maintained for one month. In a child with a history of chronic tonsillitis therapy was also continued for one week after complete clearing of the infection to avoid possible relapse.

Two of the patients who failed to respond to Madribon alone were given penicillin and Cyclamycin with remission of their conditions. A third child, who had first obtained an excellent result, suffered a relapse and was treated with penicillin after failing to respond to a second course of Madribon. One patient who did not respond to any antibacterial therapy was referred for surgical therapy.

There were no signs of toxicity or sensitivity in any of the patients. Three children suffered from sleeplessness which appeared to be due to Madribon. In two cases nightmares ceased immediately when the drug was discontinued though the illness was unchanged. In one the drug was resumed and the nightmares returned.

There were no objections to either form of medication, but the suspension was more popular with the children because of its custard-like taste.

Discussion

The clinical results obtained in this study are not comparable to those noted by other investigators using Madribon for similar infections. The results lay at extremes of the response range, being either unequivocally good to excellent or poor, with no fair or moderate responses. In a few patients with poor results, failure could be attributed to resistant strains or to the fact that the infection was of such long standing that permanent damage to the lymphatic tissues had resulted. In most instances, however, the cause of failure could not be demonstrated. As is often the case with sulfonamides, there was no correlation between the degree of in vitro resistance and the in vivo responses, indicating the importance of the individual defense mechanisms in potentiating the therapeutic response. Thus, it may be that the highly variable characteristics of childhood response to medication were strong factors in these failures, although no untoward side effects were observed in these refractory patients.

Nevertheless, the safety and general efficacy of Madribon as compared with the antibiotics warrants its use in the pediatric patient. If there is no obvious response to Madribon therapy within a reasonable time, a change in the therapeutic program is indicated. In vitro resistance to Madribon should not be a contraindication to its use, however, since it is not indicative of its in vivo activity.

Summary

Madribon in tablets and suspension was administered to 48 children with respiratory and intestinal infections.

The tablet dosages were 1 to 2 Gm. initially with maintenance doses of 0.5 to 1.0 Gm. daily. Suspension doses were ¾ to 2 drams initially with maintenance doses of ½ to 1 dram daily. Therapy was continued for from one week to four weeks, and adjunctive therapy was limited to nasal drops, throat sprays, and Otodyne ear drops.

The results were excellent in 24 children, good in six, poor in 13, with no follow-up in five. There were no adverse side reactions to Madribon, and both formulations were acceptable.

It was also noted that the in vitro activity of Madribon was independent of its in vivo activity, and laboratory resistance of a pathogen was not a contraindication to its use.

Madribon is recommended as a safe and effective alternative to antibiotics in children with systemic infections.

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Anabolic Agents as Adjunctive Therapy in Allergy

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Well known is the fact that clinical manifestations of allergic reactions result from the combination of an antigen with an antibody. A substantial body of information concerning antigen-antibody reactions has been accumulated from in vivo and in vitro studies.

Basically, the treatment of the allergic patient has not changed significantly in the past decade. It still consists of (1) elimination of the offending allergen from the patient's environment; (2) palliative drug therapy with antihistamines and/or steroids such as ACTH or cortisone derivatives; and (3) lessening of sensitivity by injection of the specific antigen. The majority of allergic patients usually respond to this regimen; however, there are those who do not. This report is concerned with those severely allergic patients who respond poorly and require long term therapy, or who, following acute allergic episodes, are unable to regain pre-illness weight, vigor, vitality and well-being.

As stated previously, initial treatment of the allergic patient is usually of the palliative drug type. Relief of symptoms is of course the first goal in therapy. In the medical armamentarium are steroids which have the ability to influence metabolic processes favorably and steroids which can control allergic responses. In this latter group, certain medications, the gluco-corticoid class (ACTH, cortisone and its derivatives), used to control allergic responses may also adversely affect metabolic processes. Hence, in treatment,

Table 1

Patient	Age	Sex	Diagnosis	Weight (lbs.)
1	32	M	Allergic rhinitis	151½
2	45	F	Asthma, bronchial	117
3	5	M	Asthma, bronchial	34½
4	49	F	Asthma, depression	154
5	6	F	Asthma, eczema	43¾
6	13	M	Asthma	70
7	12½	M	Asthma, rhinitis	78¾
8	33	M	Asthma, eczema	121¼
9	5	M	Asthma	37½
10	59	F	Gastrointestinal allergy	98
11	23	M	Allergic rhinitis	128½
12	68	F	Allergic dermatitis	91¾
13	17	F	Allergic dermatitis	107½
14	19	M	Asthma, bronchial	117½
15	18	F	Allergic dermatitis	107
16	51	M	Allergic rhinitis	165
17	21	M	Asthma, bronchial	155
18	36	F	Allergic dermatitis	116
19	40	F	Asthma, rhinitis	115
20	64	F	Asthma, cardiac	107
21	60	F	Allergic rhinitis	100
22	68	M	Asthma, bronchial	147

the balance between physiologic anabolic and catabolic processes must constantly be kept in mind. This balance depends upon the ratio of anabolic and catabolic hormones, both endogenous and exogenous. If cortisone or its derivatives are administered in less than carefully controlled dosage, the metabolic balance may be disturbed, causing a pronounced negative nitrogen balance as part of the general catabolic state. If it is allowed to continue, the patient may experience loss in weight, fatigue, apathy or mental depression, and demineralization, leading in some instances to osteoporosis.

That good nutrition contributes to a favorable response to treatment is an accepted fact. The factors contributing to metabolic balance are many, and regulation or maintenance of the balance is a delicate process.

In the past year, we have observed a number of allergic patients who have responded slowly to standard antiallergen regimens and in whom, because of prolonged treatment, certain additional symptoms indicative of negative nitrogen balance developed. Twenty-two of these patients were selected for this evaluation because of underweight, loss of strength, loss of energy, weakness, or general fatigue and lassitude. Table 1 presents the age, sex, presenting diagnosis and pretreatment weight of these patients.

The ages ranged from five to 68 years. We have not observed a preponderance of these poor responders in any age group, nor do we find that they are more frequently of one sex than the other. Severity of the allergic reaction may contribute heavily to the over-all negative clinical state, and it appears that the duration of acute allergic symptoms is a major contributing factor. In order to improve the general catabolic state of these patients, and in addition to their individual allergy treatment, we instituted the use of an anabolic agent.

Anabolic agents promote tissue-building processes, and reverse catabolic or tissue-depleting processes. They rapidly establish a sustained, positive nitrogen balance by increasing the utilization of dietary protein. Appetite may improve dramatically. The resulting gain in weight takes the form of solid, working lean tissue.

The anabolic or protein-sparing effect can be accurately verified clinically by means of determination of nitrogen balance. In normal persons as well as patients in negative nitrogen balance, a powerful, positive effect on the equilibrium between protein building and breakdown is exerted. The use of anabolic agents is not new. Their widespread use, however, has been limited because of the inherent side effects of certain available preparations.[1]

We were prompted to evaluate nandrolone phenpropionate* because of reports of its wide margin of safety in the treatment of many clinical conditions characterized by negative nitrogen balance.[2-7] The dosage was 12.5 mg. (½ cc.) to 25 mg. (1 cc.) administered intramuscularly each week. Table 2 presents the dosage, frequency of administration, duration of administration, clinical response, side effects, pretreatment and post-treatment weight and gain in weight.

* Durabolin, Organon Inc.

Table 2

PATIENT	DOSAGE (I. M.)	FREQUENCY	DURATION	RESULTS	SIDE EFFECTS	WEIGHT (LBS.) PRE	POST	GAIN
1	1 cc.	weekly	8 weeks	Good	None	151½	155½	4
2	1 cc.	weekly	6 weeks	Fair-good	None	117	119½	2½
3	½ cc.	weekly	7 weeks	Excellent	Sex stimulus	34½	39½	5
4	1 cc.	weekly	6 weeks	Fair	None	154	156	2
5	1 cc.	weekly	4 weeks	Good	Eczema flare-up	43¾	45¼	1½
6	1 cc.	weekly	8 weeks	No gain	None	70-68½	70	0
7	1 cc.	weekly	5 weeks	Excellent	None	78¾	82¼	3½
8	1 cc.	weekly	6 weeks	Excellent	None	121¼	125¼	4
9	½ cc.	weekly	5 weeks	Excellent	None	37½	41½	4
10	1 cc.	weekly	8 weeks	Excellent	None	98	112	14
11	1 cc.	weekly	8 weeks	Excellent	None	128½	134	5½
12	1 cc.	weekly	6 weeks	Good	None	91¾	94	2¼
13	1 cc.	weekly	5 weeks	Good-excellent	None	107½	112	4½
14	1 cc.	weekly	4 weeks	Good	None	117½	119	1½
15	1 cc.	weekly	7 weeks	Good	None	107	111	4
16	1 cc.	weekly	4 weeks	Undetermined	None	165	165	0
17	1 cc.	weekly	7 weeks	Excellent	None	155	165	10
18	1 cc.	weekly	5 weeks	Good	None	116	119	3
19	1 cc.	weekly	6 weeks	Good	None	115	118	3
20	1 cc.	weekly	6 weeks	Excellent	None	107	111½	4½
21	1 cc.	weekly	6 weeks	Good-excellent	None	100	104	4
22	1 cc.	weekly	8 weeks	Good	None	147	152	5

Summary

This report concerns the use of anabolic agents as adjunctive therapy in allergy. The specific use was in patients who responded poorly to the usual allergic methods of avoidance and hyposensitization to the specific offending allergen and in whom under medical management symptoms of negative nitrogen balance developed, presumably from corticosteroid therapy.

The anabolic agent evaluated was nandrolone phenpropionate, because of its record of safety and because it could be given parenterally at the same time the patient received antiallergy injections.

Twenty-two patients are reported on in detail in this report. The common signs and symptoms were underweight, loss of strength, loss of energy, weakness and general fatigue and lassitude, superimposed upon the various manifestations of allergy.

No age or sex preponderance in any category was noted. There were no local or systemic allergic reactions to dosages of nandrolone phenpropionate ranging from 12.5 mg. (½ cc.) to 25 mg. (1 cc.) given intramuscularly each week.

The results in the 22 patients were 10 excellent responses, eight good responses, two fair responses and no recognized response in two. There was one flare-up of atopic eczema, which could not be accounted for on an allergic basis in a six year old girl. One five year old boy appeared to experience some sex stimulation as noted by his parents.

Our observations in this series of patients lead us to the conclusion that nandrolone phenpropionate is an excellent anabolic agent as adjunctive treatment in depleted allergic patients not responsive to the usual treatment alone.

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The Case of the Multiple Pedicles

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Over the past 20 years countless Jackson Memorial Hospital interns, residents and attending surgeons have had a hand in the case of Jesse Young. His complete medical record is best carried in a small wheelbarrow. Thus it was thought that many doctors now scattered about Florida might be pleased to hear of his progress.

An Avulsion Accident

In 1941 Jesse, a lather by trade, was returning from the old Richmond blimp base and had reached the bridge at Eleventh Street and Fifty-Seventh Avenue when the breakline of his new motorcycle came loose locking the front wheel. In the spill he was thrown through the bridge rail onto the ground below, and the motorcycle skidded down on top of him severely avulsing the soft tissues of the anterior surface of both lower legs. In Jackson Memorial Hospital emergency room the avulsed areas were debrided. The patient remained in the hospital for 18 months during which time he underwent lateral relaxing incisions and four episodes of pinch grafting all without avail. Even at this early stage there is a strong suggestion that the vascularity of the base of the ulcers was insufficient and the extent of the infection severe. Certainly the longer the ulcers were allowed to persist the more difficult they would be to cover. By 1944 bilateral amputation was offered the patient. He refused and went under the care of a private physician who covered the legs with adhesive tape in an attempt to promote epithelization. The tape merely floated off under the barrage of discharge.

Amputation Again Advised

From 1947 to 1952 the patient was able to hold down a job with the Humane Society by dressing his ulcers himself daily. He also became clever capturing escaped animals; his most famous catch was the trapping of a Rhesus monkey which ended "Patsy's three day rampage." During the 1947 flood while salvaging 250 stranded chickens Jesse had to trudge through deep water in high boots that rubbed his ulcers. After each crate had been filled with chickens and carried to safety, he recalls pulling off his boots and pouring out the bloody fluid. Experiences like this finally precipitated the patient's return to Jackson Memorial Hospital, and during this admission a multiple-staged crossleg flap was attempted. His legs were crossed nine weeks in a plaster cast, but the discharge and avascularity prevented success and only a small mound remains in memoriam (fig. 1). Sympathectomy then was offered, but the patient refused and left the hospital to continue with daily dry dressings. By now he had slight limitation of extension of the left knee and ankylosis of both ankles requiring heel lifts. In 1956 he was examined at a conference of specialists, and according to the patient their general advice was bilateral amputation (fig. 1).

A Pedicle Plan

At this same time a tube pedicle plan was presented to the patient. It was explained to him that the many failures had been due to the virulent infection and the lack of good blood supply in the area of the ulcers and that the chance of a tubed flap success depended on the pedicle's ability to resist infection and bring in a new blood supply. The plan outlined involved constructing a long tube across the patient's entire abdomen. One end was to be swung to a point above the right leg ulcer and in time the other end could be attached above the ulcer on the left leg. The project promised to produce a tube bridge spanning between the two legs which when divided in the middle would supply sufficient cover for both ulcers. This was a sound approach, but the patient was warned that even if all went well, it might take six months for completion. He expressed his lack of concern, reminding us he

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Fig. 1. — Fifteen year old chronic leg ulcers. Arrow points to remaining mound of previous crossleg flap which, when lifted to cover the ulcer, proved as friable and useless as wet tissue paper.

had already spent over 15 years with these ulcers. A promise was made that if it was surgically possible, regardless of time or pitfalls, his legs would be covered with good skin. He went for the plan like a bonefish for a quiet shrimp and, in fact, only once looked back.

An Early Setback

In September 1956 both a right and a left flank pedicle was made. In just under a month these two pedicles were joined by tubing the center portion (fig. 2) and the first ominous sign appeared as the middle of the new portion turned blue and then black. Tubing across the midline is always a hazard, but under ordinary circumstances the precautions taken here had been found sufficient. Hindsight on Jesse would now demand the final tubing of the midportion be preceded by parallel incisions and two weeks later completion by undermining and tubing the flap. Debridement of the necrotic center left two shorter pedicles (fig. 2) which first were lengthened along the thoracoepigastric line and gradually, stage by stage, over the months "cartwheeled" down each leg toward the ulcers. Jesse's fat was extremely friable, his skin lacerated far too easily, and his tissues just did not react normally. Yet biopsies of fat, muscle and skin as well as blood chemistry studies all gave negative results.

When covering a chronic ulcer with a pedicle, it is usually advantageous to implant the ends of the pedicle into normal tissue above and below the lesion. This method produces a pedicle bridge which spans the ulcer, and once an adequate blood supply has been developed, the tube can be unrolled and let into the excised defect. By the time that pedicles 1 and 2 approached their final destination, they had shrunk to such an extent that there was only enough to cover a portion of the two ulcers. It was noted, also, when each pedicle was let directly into the infected area, it became edematous and erythematous. This development was frighteningly reminiscent of an experience by McIndoe[1] in 1935 when using



Fig. 2. — X. Long abdominal tube pedicle extending from one iliac crest to the other. Y. Central 2 inches of tube lost. Left pedicle 1 advanced to left thigh and later upper end delayed. Z. Right pedicle 2 advanced to right thigh on its way to ulcer on right leg.

a Gillies tube pedicle wick to tap a lymphedema in a lower extremity. The pedicle, being implanted below the lymphatic block, tapped bacteria along with the edema, and the patient died of a generalized streptococcal septicemia. In Jesse's case there was no lymphedema, but systemic antibiotics were used as a precaution against possible systemic introduction of the local infection. The implantations progressed without mishap, and the fact that these chronically infected and avascular sites had accepted even this much pedicle was encouraging (fig. 3).



Fig. 3. — Left pedicle 1 partially implanted. Right pedicle 2 completely implanted.

One Ulcer Covered

In June 1958 another tubed flap was constructed on the left side of the abdomen and with the aid of the left wrist as vector had arrived on the right leg at about knee level. Then came the lowest ebb of the entire pedicle campaign. The skin flap on the right leg was swung over and let into the larger ulcer on the left. As had occurred previously, the pedicle when attached to the infected area swelled and turned red, but this time it gradually pulled away and shriveled. Reattachment was accomplished, but by now it was obvious that complete cover of the ulcer on the left leg was not going to be possible with the amount of pedicle 3 still available. Jesse, with tears in his eyes, finally requested amputation. Sedation and a quiet discussion encouraged the patient to join in the planning of the next pedicle step. Together, we decided to take the remaining pedicle 3, now attached to but insufficient for the ulcer on the left leg, and cross it to cover completely the smaller raw area persisting on the right leg. In early 1959 the right leg was finished and has not produced a drop of drainage since that time. Subsequently, the patient did lacerate the pedicle by accident, but what is extremely important, the wound healed without difficulty.



Fig. 4. — Pedicle 4 attached below right knee has been implanted into remaining portion of ulcer of left leg by crossing legs.

Last Ulcer Covered

Jesse had always doubted the chance of covering the ulcer on the left leg, but when the question of amputation arose again, a fourth pedicle was suggested and accepted as a substitution. By this time the patient had developed such insight into the problem of pedicle transport that often he lay awake at night figuring out the best position for the next transplant. He was always cooperative, appreciative and popular among the house staff. Once a resident (K.B.D.) woke him at 3 a.m. to report the catch of his first bonefish, which had been hooked in the exact flats where Jesse had directed him.

By putting the patient through contortions it is possible to bypass numerous stages in the migration of abdominal pedicles to lower extremities. Yet after once using his wrist as vector, it became obvious that Jesse, with his limitation of knee motion, was not an ideal candidate for the speed-up program. Throughout his entire pedicle experience, but particularly during the transport of pedicle 4, the patient was kept in the hospital only a few days at a time and encouraged to return there only when he desired. This plan lengthened the time required for the reconstruction, but it gave a tiring patient and his pedicles valuable opportunities for rest.

As the new skin gradually had closed off the ulcers and reduced the infection, the patient noted



Fig. 5. — Both ulcers completely covered with thick serviceable skin of pedicles 1, 2, 3 and 4.



Fig. 6. — Jesse today.

increasing energy and expressed his desire to get back to work. In a last series of pedicle calisthenics (fig. 4) the tube was spread to cover the remaining defect on the left leg. Before his final discharge the presence of amyloidosis following the years of chronic infection was ruled out by a Congo red test which gave negative results.

Thus after 20 years, four of which were devoted to pedicle maneuvers, 53 operations and the use of one million 4 by 4 gauze sponges, Jesse went out of the hospital with both legs and each completely covered with good serviceable skin (fig. 5). It is over two years since coverage of the right leg and one year for the left leg. Occasionally after long hours of dependency there is a slight blistering of an area outside the pedicle implant which promptly clears with elevation and rest. Jesse has been back at work nine months, going sometimes twelve hours a day, transporting and selling vegetables. In season, he has the best tomatoes in the South (fig. 6).

Morals in This Medical Story

The necessity in teaching hospitals for house staff rotation increases the importance of the continuity of the attending staff in follow-up on long term cases. Taking selected patients into the "game" and not discounting their suggestions can become an advantage.

The value of local antibiotic therapy as proposed by Meleney[2,3] is emphasized. It was of aid in the last stages of this case, but if used in the beginning might have prevented the early failures. Beware crossing the midline with long tube pedicles. Delay surgically and delay again.

In the face of infection and avascularity the combination of patience, persistence and tube pedicles should never be underestimated. The importance of adequate convalescence for both patient and pedicles is mandatory during extended surgical treatment.

The embarrassment of the years required and the lack of a smooth cosmetic result are offset in part by the final success with prevention of bilateral amputation and functional cover of all ulcers.

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ABSTRACTS

Carcinoid Tumors. By William T. Williams, M.D. South. M. J. 53:629-632 (May) 1960.

Five cases of carcinoid tumor of the gastrointestinal tract are reported. A limited discussion of location, symptomatology, pathology and prognosis is presented. In publications dealing with this tumor, the terms "benign carcinoid" and "malignant carcinoid" are frequently used although, pathologically, one is indistinguishable from the other. Usually the term malignant carcinoid is used to classify the lesion which has metastasized at the time of observation. Occasionally the tumor is described as potentially malignant rather than benign or malignant. Because of the inability to distinguish the two forms pathologically, the author suggests that it would seem appropriate to label all carcinoid tumors as malignant neoplasms. He also suggests that a more aggressive surgical procedure be employed in certain instances of carcinoid of the rectum.

Diabetes, Atherosclerosis and Hypercholesteremia: A Preliminary Report on the Study of Dietary Control. By Seymour L. Alterman. Postgrad. Med. 28:112-120 (Aug.) 1960.

Extensive research has indicated a definite relationship between atherosclerosis and hypercholesteremia. Since both of these conditions are often prominent in diabetes, it would seem wise to keep the serum cholesterol of diabetic patients in a low, normal state. The main approaches to this objective are through diet, chiefly by substitution of polyunsaturated fats for saturated fats in the diet. The author is among those workers who consider that the intake of fat is excessive in the standard diet recommended by the American Diabetes Association and therefore has no lipid-lowering effect. He has found that a modified form of the diet, with unsaturated fats substituted for saturated fats, has effectively reduced serum cholesterol levels in diabetic patients. He reports that the diets he proposes in this article have been readily received by intelligent patients seen in private practice and have been found palatable and easy to prepare. The use of low fat diets in conjunction with the substitution of unsaturated fats for saturated fats in these patients has successfully reduced serum cholesterol levels.

Cancer of the Mouth and Throat: Therapy and Repair. By Richard T. Farrior, M.D. South. M. J. 53:1021-1030 (Aug.) 1960.

This presentation deals with the management of cancer seen in the routine oral physical examination as it should be performed by all otolaryngologists. Surgical therapy, when operation is feasible, is outlined with consideration given to the lip, alveolus and bone of the jaw, buccal mucous membrane (cheek), floor of the mouth, tongue, tonsil, palate, salivary gland, pharynx and larynx. The group of malignant lesions discussed accounts for 5.5 per cent of all cancer deaths, a significant figure, especially when as high as half of the deaths could be prevented with early detection, a responsibility of the otolaryngologist. Cure rates would be even higher with combined early detection and adequate initial excision. Likewise, individualization of each case would produce better cure rates and also in many instances would allow better preservation of function.

The author emphasizes that there can be no standard or routine operation in cancer surgery. Each individual lesion must be regarded separately and each individual must be evaluated separately. The condition of the patient, the exact location of the lesion, the degree of anaplasia, and the presence of regional metastases influence the therapeutic modality to be chosen. With regard to whether reconstruction should be total or partial, now or later, Dr. Farrior is of the opinion that primary reconstruction should not be considered if there is a remote possibility that its use would influence adequate excision. With correct thinking he believes that familiarity with reconstructive technics allows radical excision more often than it prevents adequate excision. In advocating the preservation of tissue, accepted principles of cancer surgery cannot be violated concerning the margin of normal tissue which is to be taken with the specimen.

President's Page

The Florida Medical Foundation

The Florida Medical Foundation is a nonprofit organization having for its purpose "to promote better medical care in Florida." This Foundation was established by the House of Delegates of the Florida Medical Association in May 1956.

In order to obtain tax exemption status some changes were required in the charter, especially with reference to the objectives of the Foundation. The Internal Revenue Service, in January 1959, stated that the Medical Foundation was exempt from federal income tax and that contributions were deductible.

The revised objectives of the Foundation are as follows:

1. Improvement of the health and of the medical care of the people of Florida.
2. Sponsorship of graduate and postgraduate medical education without preference for any person.
3. Aid to persons of Florida needing financial charitable assistance who are pursuing an education in medicine.
4. Aid to deserving indigent or destitute physicians who by reason of illness or mental or physical incapacity need charitable assistance.
5. Promotion and sponsorship of medical research exclusively for public purposes and benefits.

This is the season of the year when we hear most often the phrase, "Peace on earth and good will to all men." I think it is most appropriate that we at this time express our feeling of good will by making a generous contribution to this fund. From the objectives listed you can designate where you want your money to go. The student loan fund and the aid to deserving indigent or destitute physicians particularly need building up.

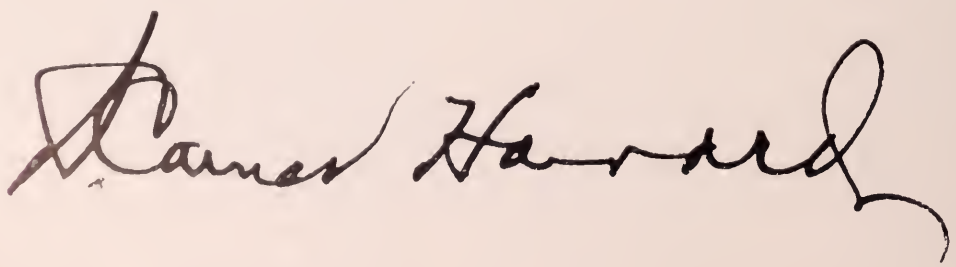
This fund is growing each year. In 1957 there were 33 donors, in 1958, 18, in 1959, 331 and in 1960, 417. The amount paid in last year was $6,151.25, which does not include research grants. This is a good amount, but nothing like as good as it should be. Remember this is your fund and in a measure your financial contribution for the advancement of medicine.

There are a good many capable and deserving young men who are being kept out of medical school because of lack of funds. I know of no way that our money could go any further toward helping more people than by helping one of these deserving young men.

During my lifetime I have seen several good physicians who through poor management, sickness, or other misfortune have been made destitute. Without exception they are too proud to call for help and will always insist that they do not need it. Certainly we owe to them our undying gratitude for their past deeds and in what way can we express this better than by making them comfortable at such a time? For—

"It is in giving—that we receive."

St. Francis.



Indicator-Dilution Techniques

Indicator-dilution techniques, one of which is the subject of an article in this issue of The Journal ("Newer Methods for Detection of Congenital Cardiac Shunts"), have been available for some time. In 1951 Bing[1] reported the use of Evans blue dye (T-1824) for dye dilution curves from the right side of the heart. This method has a serious disadvantage in that it requires that during the 30 to 60 seconds that the blood sample is withdrawn the oxygen saturation of the blood must be assumed to be constant. Radioactive indicators overcome the oxygen saturation difficulties, but pose new problems of handling and irradiation.

The search for a dye which would meet the many requirements requisite to dye injection techniques was carried out extensively in the laboratory of Dr. Earl H. Wood of the Mayo Clinic. Particularly notable was the work of Dr. I. J. Fox in conjunction with Dr. L. G. S. Brooker of the Eastman Kodak Research Laboratories. As a result of the efforts of these investigators and many others, the dye "cardio-green" (indocyanine green), a dye more suitable for use in indicator-dilution techniques, was developed. "Cardio-green" has the marked advantage of having its peak light absorption at 800 millimicrons, which is the point where oxyhemoglobin and reduced hemoglobin transmit light equally. It is also a wave length at which the infrared photo cell of the oximeter has its peak sensitivity, and therefore variations in the amount of oxygenation of the hemoglobin in the blood have no effect on the results obtained in the recording of indicator-dilution curves with this indicator dye. In addition "cardio-green" is water soluble, nontoxic and suitable for sterilization so that it can be utilized in aseptic techniques and for sterile intravenous injections.

The various detailed descriptions of "cardio-green," its development, and its application to all parts of the cardiovascular system concerning the diagnosis of intracardiac shunts, determinations of central and total blood volumes, circulation time, cardiac output, and various liver function studies have been well documented in a series of publications concerning indicator-dilution techniques which have emanated from Dr. Wood's laboratory since 1956.[2-6]

Although the indicator-dilution technique utilizing "cardio-green" is an excellent one, unlike the present authors we have not discarded the less accurate oxygen technique completely, but preferably use the two techniques together in a complementary method.

In the discussion of a dye dilution pattern of the left to right variety, the authors give as an example "a young boy with an Eisenmenger's complex." This is a poor example since Eisenmenger's complex is not an example of a left to right shunt, but is an example of a mixed shunt which is most often predominantly right to left.

A point of clarification concerns the right atrium as an injection site. It is important when one wishes to inject from the right atrial area that the catheter tip be positioned as exactly as possible so that several obvious pitfalls can be avoided such as injection into the coronary sinus ostium or into a patent foramen ovale. It is much better to situate the tip of the catheter exactly at the junction of the superior vena cava and the right atrium or at the junction of the inferior vena cava and the right atrium.

It has also been well documented that on occasion one may see a right to left shunt in an ostium secundum defect after superior vena caval injection. This type of right to left shunt after superior vena caval injection does not automatically mean a sinus venosus type of atrial septal defect, but can mean nothing more than the usual type of interatrial ostium secundum type septal defect. In the initial series of interatrial communications reported by Swan,[7] seven of the 11 cases did show a right to left shunt with the inferior vena caval injection, and four of the 11 cases showed a right to left shunt with a superior vena caval injection.

There is also some question about the similarity of indicator-dilution curves after injection into the right and left atria of a patient with total anomalous pulmonary venous drainage. The drainage pathways in this condition from the two atria are not similar. Dye injected into the right atrium will have a far different dye curve than

dye injected into the left atrium. Dye put into the left atrium mixes with a relatively small amount of blood and this dye mixture goes right out to the peripheral sampling site and would tend to transcribe a normal curve although it might show a low output. Dye injected into the right atrium is mixed with a relatively large volume of blood and the dye-blood mixture from that point goes into two separate areas: (1) to the left heart through the functional defect in the atrial septum; (2) into the right ventricle and out the pulmonary artery.

Additional uses of indicator-dilution techniques include the more accurate selection of the site for injection of contrast material in angiocardiography. By utilizing indicator-dilution techniques in this manner, the catheter tip can be positioned in a tetralogy of Fallot so that the majority of the contrast media can be injected in such a manner that most of the dye goes out the right ventricular outflow tract and through the pulmonary artery delineating the anatomical area in question and sending only a small amount of dye across the ventricular defect. This type of injection considerably diminishes the amount of relatively undiluted contrast material going to the brain.[6]

In conclusion, the use of indicator-dilution techniques utilizing "cardio-green" has been a revolutionary step forward in diagnosing congenital and acquired cardiovascular defects. Dr. Wood and his group at the Mayo Clinic have certainly made an outstanding series of contributions in this respect.

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MYRON W. WHEAT JR., M.D.
GAINESVILLE

What Price Welfare?

Christmas is the time of giving; the tradition of helping others is a well established tenet of the Judeo-Christian ideal and no one of us would want it diminished one iota. Yet evidence is mounting steadily that, as the New Year begins, Americans need badly to examine the system of governmental handouts, with no attention to whether or not they are deserved, which has become part and parcel of political life.

The plight of Newburgh, New York, a city that discovered how its very life was being destroyed by the cancer of unrestricted welfare handouts by governmental agencies at all levels, startled and shocked many Americans. It seemed unbelievable that the tradition of individual effort fostered by our forefathers should have been so completely undermined by the anxiety of governmental agencies to hand out money to people, of whom the only effort required was to hail a taxi and ride to the welfare office. As the facts were uncovered, it became quite evident that Newburgh was suffering gravely from a malignant social tumor, as were many other communities across the face of the land. Yet when radical surgery was undertaken, the howls from those who gained most through the system, the bureaucrats who administered it at all levels, were far louder that the cries of those deprived of free support and forced to go to work.

If this country is to survive as anything resembling the democracy of stalwart individuals standing upon their feet through the free enterprise system that it was intended to be by the men who died at Lexington, Concord, and Valley Forge almost two hundred years ago, the headlong rush toward the ultimate disaster of a welfare state must be discouraged. Traditionally, the medical profession has always been in the forefront of this battle; even now we are under heavy fire to bring us, too, under the domination

of the government. If we fail to stand firm, the cause is lost beyond redemption.

Twenty years ago this writer portrayed in his first novel the evils of government - controlled medicine, a system similar to the one now proposed for the upper age levels of the population under the guise that Social Security is a form of insurance, when any high school student of government knows that it is not. Much of the material for that novel came from early reports concerning the experience of England with its National Health Service. Twenty years later, critical studies of the British experience are being widely published, studies made by English social scientists, not doctors. What they tell of the effect that government control has had on British medicine is both shocking and saddening. In fact, the truth has turned out to be considerably more harrowing than it was portrayed in fiction.

Medicine is primarily a calling, not simply a profession. Men are drawn to it by the instincts of the humanitarian and scientist and rarely do the tangible rewards exceed the intangible. The British health insurance scheme has, quite predictably, turned out to be over-costly, inefficient, and afflicted with a massive inertia. The worst effect, however, has been a deadening of the enthusiasm of young men to enter the profession of medicine. When the betterment of a doctor's scale of living consistently lags behind that of the general population, one can hardly expect even dedication to bring young people into medicine. In fact, this sapping of the very lifeblood of a vital profession by the stultifying effects of governmental control is the greatest danger in the schemes proposed by those who would make America a welfare state.

The medical profession is already finding itself in the position of being the "thin gray line" standing between true democracy and a system that makes a mockery of human ambition and effort. However difficult and costly the role, it must not even consider surrender.

Frank G. Slaughter, M.D.
Jacksonville

Editor's Note: This is the ninth consecutive year The Journal has published a December guest editorial by Dr. Frank G. Slaughter of Jacksonville, Florida's distinguished physician-author.

The Supreme Miracle of Christmas

It was old home week in Bethlehem. The emperor had declared a census should be taken, and everyone should register in the city of his birth. So half of the population of Palestine was shuttling across country for the enrollment. Elaborate festivities were planned in every community for the grand homecoming that was in progress. The large cities, like Jerusalem and Capernaum, were greatly diminished, but the towns and villages were filled to capacity by their returning kinsmen.

It was at this season that Jesus Christ was born in the town of Bethlehem. There was merrymaking in the streets that night, no doubt, but it was arranged for the paying guests. No one took note of the Child born in a hotel stable. Strange, for the startling announcement of "a man in space" would not be so amazing as a declaration of the Scriptures concerning the birth of Jesus Christ. The space age, miraculous as it is, will prove the complete undoing of our race unless it is entered under the sovereignty of this incarnate Son of God.

The supreme miracle of Christmas is not the virgin birth. It is the incarnation. It is the fact that the Spirit of God became incarnate in the body of man and for thirty-three years thereafter dwelt among men—teaching—healing—comforting—inspiring. He answered their age-old questions: What is God like? What does God want? Where can God be found?

A week before Christmas Day some friend will casually comment to you that he hasn't yet "gotten the Christmas spirit." You will know what he means. He hasn't yet become feverishly concerned about all the things he's going to buy and all the plans he's going to make for what he calls the celebration of Christmas.

After all, what does it take to give one the "Christmas spirit?" A few years ago Olin Stockwell emerged, lean and ill, the last American missionary to come out of Communist China. Before his release he had been in prison two years —fourteen months in solitary confinement. He said, "Last Christmas I was in a solitary cell. Suddenly out of the stillness from the cell next

to sing a beautiful Chinese voice was singing 'O come all ye faithful, joyful and triumphant; O come ye, O come ye to Bethlehem.'" That, I say, is the Christmas spirit. When the sublime fact that God has in Christ revealed the answer to all our deepest hunger, the secret to all our distresses, the fashion by which all life must be lived, we discover the Christmas spirit in its original sense.

This Child, born in a stable, to a mother whose husband could get no reservation in the Inn, is God's answer. In fact, in spite of the superficiality with which men have generally accepted Him, He is recognized as the Supreme Personality of the race and His life has profoundly affected both individuals and society wherever He is known.

An author, returning from the West, wrote of one scene: "The vistas here stretch the eyes, enlighten the heart, and make the spirit humble." This is something of the effect the very story of the life of Christ has upon mankind. But in a moment of social, economic, cultural, and international crisis such as our day presents, the fact that God has revealed both the principles and the power by and through which alone all our problems can be resolved should give us a new kind of Christmas spirit. When this fact comes home to us, we will hasten abroad like the shepherds after their visit to Bethlehem, telling everyone we see of the glory which has been revealed to us with regard to this King of Kings and Lord of Lords.

James W. Henley, Resident Bishop
The Methodist Church,
Jacksonville Area

Editor's Note: This is the first in a series of guest editorials appropriate to the season by leading ministers within the state published upon solicitation in the hope that physicians will find these messages a source of guidance and inspiration.

Four Organizations and Their Role in the Problem of Juveniles

> Train up a child in the way he should go, and when he is old he will not depart from it.
> Proverbs 22:6

What a wise statement made hundreds of years ago by the prudent King Solomon! It is as timely today as it has been for past generations —and will be for future ones.

A great deal is being heard about juvenile delinquency and the causes fostering it. It would seem that all the contributing factors have been cited in the volumes of papers and books written on the subject; yet the home, the church, the school and the community must take their fair share of the blame for failing the children.

The home, an institution ordained by God, is not a materialistic structure but a relationship between husband and wife and their children. A child has a much better chance of growing to maturity as a well adjusted individual if he enjoys the security of a good home, and promoting this feeling of security is the love his parents have for each other. In their love, the child should see evidence of mutual respect, understanding, interest and teamwork. There should be laughter and happiness, which demonstrate to the child that the "home front" is united. Proper discipline is a source of security. The child may object strenuously to being disciplined, but, at the same time, he is not wise enough to guide his activities properly and must look to his parents for this guidance. If the parents are divided in their approach, the child loses his respect for them and in so doing feels bewildered and insecure.

We have juvenile delinquents because we first have delinquent parents. On his day off, Dad is too busy playing golf to spend time with the children. Mother is too busy with housework and club activities to know where the children are and what they are doing. It is all right for Mother to be club president and engage in other worth while activities as long as she does not neglect her children. If she does, one day the realization may come that she has fostered a delinquent of her very own. It is not the responsibility of the neighborhood to be a baby sitter. Besides, it does not make a very good one.

The churches are failing the children by emphasizing the social and recreational needs of the individual. The attraction should not be hamburgers, hot dogs, bingo, ping pong, and the like; it should be duty, love and devotion to their Cre-

ator which draws them there. Their reward for attending should be spiritual truths which will strengthen and fortify them against the temptations and disappointments of life. The churches need to teach Christianity and leave recreation to the home and community. They should combat a religion which for too many has become so superficial that one goes to church to further his social status, to promote a job or his position in the community.

It has been said that "families that pray together stay together" and, no doubt, there is a great deal of truth in the statement. Many parents make no pretense at attending church; however, some do send their children while they remain at home reading the daily newspaper. Training a child in the way he should go must be by example, and families that go to church together and worship God together rarely go to juvenile court together.

The schools also must share in the responsibility for the juvenile problems. Fortunately most teachers are dedicated, capable, with high moral standards; however, as in every other profession, there are those whose moral character is questionable and no doubt they have a deleterious effect on children since the teacher is often the model for the child. The responsibility of the teacher, therefore, is great, but the responsibility of the parents is even greater in seeing that the children have a good "model."

Many boys and girls lack the capacity to excel and become disinterested when forced to continue studies they cannot or will not grasp. This situation creates boredom; boredom results in truancy, and truancy leads to delinquency. Rather than force them to stay in school, they should be allowed to attend a school created to teach a trade whereby they can earn a living for themselves and contribute to society.

The community has a decided obligation to its youth. There should be more and better facilities for sports and other recreational activities. There should be safe, well supervised playgrounds where children may go to expend the boundless energy that only youth possesses. There should be more policemen to patrol play areas because those who would molest children frequent them. Well organized, supervised and protected playgrounds would be costly, but $40,000 would go a long way in creating such a place, and approximately this amount is required to process one delinquent through the juvenile court.

Granted, however, that there always will be children in trouble in spite of all good intentions, the community has the responsibility to maintain facilities for their care which will assist in the salvage of as many of them as possible. At present, many facilities are wholly inadequate and completely understaffed. Youthful first offenders must be returned, many times of necessity, to the same environment which propagated their trouble in the first place. This is due to the need for adequate homes to which they may be sent for rehabilitation while an effort is made to improve their own home environment. Such facilities should be financed wholly by the community through taxes and not be dependent upon various civic clubs to bolster the inadequate funds available for operation.

It takes a great deal of training to bring up a child in the way he should go, and the home must be the primary training ground. The church, the school and the community can be aides only and never a substitute. Each one, however, should make every effort to create the proper environment, for in children is the hope for the future.

James R. McCain, M.D.
Jacksonville

OTHERS ARE SAYING

The Curse of Something for Nothing

By F. L. Maus

A bank president has implicit faith in the integrity of his cashier. The cashier suddenly absconds with fifty thousand dollars of the bank's funds.

A man hurries through a New Year's throng in Times Square. He reaches for his purse. It is gone; picked by someone in the crowd.

The vacationing members of a family return to their home in the city. It has been ransacked. Valuable possessions are missing.

Two armored-car guards are shot down in a bank entrance without warning. Two other men with smoking guns grab the fallen pouches of currency and disappear.

If you are a regular reader of newspapers, the events briefly described above should have a familiar ring. Perhaps, at one time or another, you may have wondered how it happens that an

able-bodied adult gets himself to the point where he will commit such crimes.

There are at least two truths about such actions that are obvious, although they are frequently overlooked. The first of these truths is the simple fact that a person who commits a crime similar to those mentioned must do some thinking and planning to get the deed done.

"How then," one might ask, "does the thinking of such people get so grooved as to lead them ultimately down the road of crime?"

The answer to that question deals with the second obvious truth about the criminal behaviour previously described. It is this: In each of the four crimes mentioned, the villain in the act took something that did not belong to him; something he had not earned; something for which he was offering nothing in return; *something for nothing.*

There is in almost all of us, old enough to think, that ageless dream of acquiring something for nothing, in large or small amounts. Some of us buy lottery tickets at almost every opportunity. Some of us play the numbers racket. Some of us secretly look forward to the death of a rich relative, expecting him to remember us generously in his will. Some of us sue others for substantial damages when, in fact, little or no damages were really suffered. Some of us eagerly seek tips on the stock market or the horse races. Some of us succumb to the fascination of the slot machine or the roulette wheel. And many of us recall, with feelings akin to nostalgia, the enchantment of our childhood belief in the pot of gold at the end of the rainbow. And so it goes, an almost endless refrain: *Something for nothing. Something for nothing. Something for nothing.*

Constantly thinking about getting something for nothing can lead to constant scheming about how to get something that way. As a result, all desire truly to earn one's way of life may become lost. And, if that happens, getting without giving can become the accepted method of seeking a livelihood. Therein lies the answer to the question as to how the thinking of some people can get so grooved as to lead them ultimately down the road of crime.

However, only a relatively few people permit the appeal of something for nothing to lure them into acts of crime. Others, stopping short of crime, permit themselves to be lured into the squeamish life of a panhandler. Still others develop a facility for cheating within the law. And still others succumb only to the extent of acquiring a general disposition to be irresponsible or lazy, the reason for which they never seem quite able to understand. They know only that they are more or less constantly hoping that, somehow, somewhere, their ships will come in without much effort on their part.

The large majority of people, however, seem to suffer little or no personality damage from indulging in the quite human pastime of hoping to get something for nothing. But, there is another aspect of this something-for-nothing stuff that is far more serious than a simple case of armed robbery.

History is strewn with the wreckage of men and of nations lured to their destruction by the bait of something for nothing—lured by smoothly planned appeals to the criminal tendencies that lie dormant and unrecognized in almost everybody. And the lure succeeded only because its true nature was invariably hidden under a barrage of righteous propaganda.

It may well be that history is subtly being compelled to repeat itself; perhaps on a much larger and rascally scale than ever before. Already, enough of the people may have swallowed the bait to cause some impartial historian in the distant future to write a book entitled: "The Collapse of the Twentieth Century Civilization—An Era of Something for Nothing." He may describe in some detail the manner in which unscrupulous and clever public leaders fooled hosts of sincere folks back into misery and slavery with that old fable about the pot of gold at the end of the rainbow—Caesar's rainbow.

Perhaps the future historians will say something like this:

Even in the United States of America, which was the last remaining hope of the world in 1960, colossal give-away schemes, carefully disguised by a scholarly brand of double-talk, had already corrupted millions of mature and able-bodied people into the belief that their personal welfare was the responsibility of someone else—that they should rightly be supported by the product of other people's efforts and not their own!

Those right thinking leaders in the nation who sought to reveal the gigantic hoax were reviled and ridiculed. They were too late. The clever and unscrupulous ones had too successfully endowed with the halo of righteousness their unholy gospel of something for nothing. And their clever success was in no small measure abetted by those popular and breezy intellectuals who assured all

who would listen that the people, simply because they could enter a voting booth, were justly entitled to whatever they chose to vote to themselves.

And so, confused by intellectual half-truths and by subtle but outright falsehoods, the people were persuaded to forget that personal usefulness is the only highway men may travel in a successful pursuit of liberty and happiness. In substitution for the truth they were trapped into forgetting, the people were systematically persuaded to believe that, if they would but worship at the feet of "all-wise" government, a constant flood of something-for-nothing would bring a harvest of "security" to all. Of all the crimes committed in that dazzling but foolish era, this was the greatest.

Ideas on Liberty—September 1955 #2

The Record
Broward County Medical Association
July 1961.

CLINICAL COMMENT

Annual Meeting American Roentgen Ray Society

The sixty-second annual meeting of the American Roentgen Ray Society was held at the Deauville Hotel, Miami Beach, Sept. 26-29, 1961. The meeting was called to order by the President, Dr. Harold G. Reineke, of Cincinnati. Dr. Train Leucutia, of Detroit, was installed as president-elect.

Forty-eight scientific papers were presented during the morning sessions. Angiography received considerable attention with subjects including "Congenital Variations Encountered in Cerebral Angiography," "Angiography as an Aid in Determining Resectability of Lung Cancer," "Transaortic Catheter Opacification of the Left Ventricle," "Extra Large Field Angiography" and "Physical Aspects of High Pressure Angiography, Lymphangiography, and Renal Angiography." A paper of special interest dealing with this subject concerned "Flexible Tubing for Flow-guided Cardio-vascular Catheterization and Visualization." Flexible elastic tubing is used instead of ridged cardiac catheters, and the tubing is carried by the blood stream rather than manipulated into position. The tubing is introduced into the venous system percutaneously. This paper also discussed possible related advances coming from catheter visualization of the vascular system such as interarterial, nonsurgical grafting of blood vessels.

The afternoons of the meeting could be divided between some 44 scientific exhibits covering a wide range of subjects, and the instruction courses under the direction of Dr. Harold O. Peterson of Minneapolis. Of special interest to many radiologists was the course on mammography given by Dr. Robert L. Egan of the M. D. Anderson Hospital and Tumor Institute, Houston, Texas. Dr. Egan described in detail the technique of mammography employed by that institution and stated that successful examination of the breast is 95 per cent based on successful roentgenography. He reviewed the results of five years' experience and over two thousand such examinations. Many observers gained the impression that, with Dr. Egan's technique, the breast adapts itself to roentgen examination nearly as well as do the lungs.

The annual Caldwell lecture was delivered by Dr. Harold O. Peterson, Chairman, Department of Radiology, University Hospital, and Professor of Radiology, University of Minnesota Medical School, Minneapolis. In discussing his subject, "The Radiologist and the Special Procedures," Dr. Peterson suggested that many of the so-called special procedures now being done by another physician with the help or cooperation of the radiologist and/or the Department of Radiology could just as well be done solely by the radiologist. It was suggested that this approach would result in some of these procedures being performed by fewer persons with more experience and skill and would produce better technical results and hence more benefit to the patient.

Marvin V. McClow, M.D.
Jacksonville

Annual Scientific Assembly Florida Academy of General Practice

Diagnostic clues and practical management consideration of several entities frequently dealt with in general practice were presented to the Florida Academy of General Practice at its Twelfth Annual Scientific Assembly, held in the Diplomat Hotel, Hollywood, October 6 through 8, 1961. Program Chairman, Walter J. Glenn Jr., M.D., provided a brilliant array of speakers for the morning programs, leaving the afternoons and evenings open for recreation.

R. Bruce Logue, M.D., Professor of Medicine at Emory University School of Medicine, in three separate appearances on the program discussed diagnosis in congestive heart failure, coronary disease, and cardiovascular disease in general. He noted the multiple factors causing atherosclerosis and commented on its treatment. The diagnosis of angina pectoris and infarction is often missed, he said, by the application of too rigid criteria based on laboratory and electrocardiographic findings, rather than on clinical grounds.

John B. Miale, M.D., Professor of Pathology at the University of Miami School of Medicine, directed his remarks to the office diagnosis and management of anemia. He decried the use of therapy of this condition without first determining its cause, which basically, he stated, is due either to loss of blood cells or to failure of their production.

"Tuberculosis Revisited" was the title of the talk given by Charles A. LeMaistre, M.D., Professor of Medicine at the University of Texas Southwestern Medical School. He discussed the causes of failure of treatment of tuberculosis and related the types of tubercle bacilli to clinical types of infection.

In presenting emergency room problems, Robert H. Kennedy, M.D., Director of the Field Program Committee of the American College of Surgeons, offered some of the results of a survey made by him on this subject. He emphasized in the care of the patient with multiple injuries the necessity of having one physician, either a general practitioner or a general surgeon, as captain of the treatment team. He also pointed out many of the errors made in the handling of such patients.

A panel discussion by Nylene E. Eckles, M.D., and Richard G. Martin, M.D., both of whom are on the teaching staff of the University of Texas Postgraduate School of Medicine and the Anderson Hospital and Tumor Institute, brought out many practical and humanitarian principles to be applied in the surgical and medical management of terminal cancer. They weighed the many available palliative drugs and procedures in the light of which ones would be most valuable for the whole patient.

Leo H. Siegel, M.D., attending gastroenterologist, Presbyterian Hospital Unit, United Hospitals, Newark, N. J., crystallized the many facets of the diagnosis and treatment of patients with functional disorders of the gastrointestinal tract. His recommendations to make such diagnoses on the basis originally of thorough history and physical examination and to handle such patients with sympathetic understanding were well received.

The meeting was rounded out by sessions of the Florida Academy's Board of Directors and of the general membership, and by nightly social events.

Leo M. Wachtel, M.D.
Jacksonville

Annual Fall Meeting Florida Orthopedic Society

The annual fall meeting of the Florida Orthopedic Society was held on October 21 and 22 at the Boca Raton Hotel, Boca Raton. Six formal papers were presented by members of the society, and a discusser had been perarranged to comment on each of the papers given. During the afternoon session on Saturday, six members presented case studies representing either a good or bad result from their private practice. Again a preassigned discusser commented on the case and opened the discussion. In this way a great deal of interesting and helpful information was presented.

The guest speaker, Dr. Daniel C. Riordan, Clinical Professor of Orthopedic Surgery at Tulane University School of Medicine, New Orleans, presented a most astute and interesting discussion covering all phases of acute trauma to the hand. The material ranged from basic anatomy and the mechanism of injury to definitive surgery. He stressed several points in diagnosis, management and surgical techniques. Acute infections may present clinical findings on the dorsum of the hand, yet the basic pathology and abscess formation are on the palmar aspect, necessitating the surgical approach to be directed in this area. Partially amputated parts can be determined to

be viable by the tourniquet test, thus helping to decide whether or not to perform a primary amputation or try to salvage the part by the determination of the presence of adequate circulation. Complete disruption of blood supply to the part is the indication for considering primary amputation as any amount of reconstruction would be destined to failure. A most interesting problem is the degloved hand or finger. Often following replacement, there results a secondary slough of the replaced skin flap. This can be avoided by defatting the skin and thus utilizing it as a split-thickness primary graft. The results following this procedure, combined with the usual cleansing and surgical debridement, are most satisfactory. Dr. Riordan also stressed the importance of meticulous care in the handling of tendon injuries and discussed the many important aspects of flexor tendon repairs in and around "no man's land."

A different type of scientific program is being planned for the annual spring meeting to be held in conjunction with the annual meeting of the Florida Medical Association in May.

Philip O. Lichtblau, M.D.
West Palm Beach

AIDS TO PRACTICE

Question: How can a doctor guard against misappropriation of his money by a dishonest aide?

Answer: Compulsive and hardened embezzlers are very few among medical assistants, we are convinced. But dishonesty of this type, especially in infrequent, small amounts, may be compared to some diseases—it tends to arise when the environment is conducive. Good "internal controls," axiomatic in accounting principles, based on a definite separation of the bookkeeping function and the cashier function, are not practical in most medical offices. It is wise, therefore, to utilize other standard office procedures and practices to the extent they are practical in each office. The first of these would be recognition by the physician that the money handling and bookkeeping functions are of importance to him, that they should be granted adequate time for their proper, precise maintenance, and that authority and responsibility for these functions be firmly placed.

Select your medical assistant with care. Have a telephone conversation with her previous employers; do not give merit to letters of recommendation. Bonding your aide is of questionable value, but the application for a bond will bring about a substantial search of her background relating to the subject.

Require your day book or "daily log" to be a complete register of all patients served each day, whether a fee is charged or not; at irregular, unannounced intervals approximately monthly or quarterly, compare a pocket list of patients seen by you with those shown on the log. Some charge-slip systems, and some patients' accounts bookkeeping systems such as the Todd-Hadley or ABC, have a built-in check for omissions if properly used. Insist that a receipt (prenumbered and personalized by the printer) be issued for all currency and coins received. Deposit intact all monies received to your business bank account as of each working day so that your bank statement will be a substantiation of your log. A restrictive endorsement "for deposit only" should be stamped on each check received at the earliest practical moment. Do not "dip into the till" yourself, or, if you must, give your cashier some signed receipt for the monies so used.

Establish and maintain a "control account" for your detailed patients' accounts. Then, have a quarterly or annual audit of cash accountability if you do not regularly use a management service or independent accountant. All this will help and please your conscientious assistants and will discourage most misappropriation tendencies.

Question: Like most physicians, I have had no formal education in economic subjects or training

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Questions and comments on appropriate economic and practice management problems are invited for publication in this column. Answers to your questions will be provided by a panel composed of various Florida members of the Medical-Dental-Hospital Bureaus of America.

in business matters. Yet, I would like to know at least the elementals of insurance, investment, long term financial planning and other matters applicable to my practice and my home. Is sound, unbiased information in capsule form available to me from sources that are not trying to sell me something?

Answer: A workable and money-saving acquaintance with economic and business matters can be developed with sufficient interest on your part and a relatively little application of time. Some Florida colleges offer evening adult classes or correspondence courses on economics, insurance, investment principles and a number of allied subjects; we know of some physicians and their wives who have enjoyed such courses. You already know of the value of "Medical Economics" magazine. A subscription to "U. S. News and World Report" or "Time" can keep you posted on general business conditions and some of the factors which affect them. "Changing Times," the Kiplinger service for families, 1729 H Street, Northwest, Washington 6, D. C., is brief, interesting reading. And, if you are serious about this thing, buy some of the publications ($1.00 each) or become an annual sustaining member of the American Institute for Economic Research, Great Barrington, Mass. This is an independent, scientific and educational organization engaged in impartial economic research; its publications are designed for the nontechnical reader, among them: "Life Insurance and Annuities From the Buyer's Point of View," "What Will Deflation or More Inflation Mean to You?," "Investment Trusts and Funds From the Investor's Point of View," and "Economic Tides and Trends, Their Effects on Your Lifetime Plans."

LETTERS

October 26, 1961

Dear Sir:

Has medical internship lost its usefulness? The answer to this question is an emphatic NO.

We hear much criticism today against internship. Is it justified? Is it still serving a useful purpose? Why is the internship being attacked so universally? Those who criticize fail to see the main reason behind the opposition to a traditional training period which has long proved its worth without question.

The problem centers around the American Medical Association's Council on Education and Hospitals which has approved internship programs around the country so indiscriminately that almost any hospital medical staff can have an "internship" for its hospital by meeting a few established criteria.

How can you approve two to three times as many internships as there are interns to fill them without creating chaos, by competition between medical centers, between hospitals and medical centers, and between hospitals. Most hospitals not directly affiliated with medical schools want interns for the sole purpose of covering the hospital 24 hours a day—to man the emergency room, to scrub with the private physician, to start blood transfusions and to answer the numerous calls from the floor nurses for patients requiring an order for medications for pain, laxative, sedation and the like.

I personally feel my internship was excellent. It was a rotating type at Temple University Hospital in 1955. Unfortunately, this fine medical center discontinued its internship later—NOT because the program had lost its usefulness, as many proclaim, but because of the increasing competition among hospitals for interns.

A short distance away, another non-medical-school-affiliated hospital was getting interns. Why? Because it offered $400 monthly in comparison to the $25 monthly Temple was willing to give. It is indeed a sad thing for a medical school graduate to be forced into taking an inferior intern training program simply because the excellent one was unable or reluctant to offer a living stipend.

In this column, The Journal encourages open discussion of controversial subjects. Letters, to be published, should be in good taste and signed by the authors. The opinions expressed are those of the author and not necessarily of The Journal.

There should be only enough internships available as there are medical graduates to fill them, and these should be at university-affiliated hospitals only, where the practicing physicians also hold positions of academic rank in the medical school. Stipends should be realistic so that a married intern with a family can live adequately through the year. Unless significant changes in the internship approval system are made now, the internship as we knew it in the past will disappear from the scene.

The intern year should be a well regulated and supervised year of training in the care of the sick and injured. It should not be one of increased leisure time spent in the sun, accompanied by high stipends and fringe benefits. The practicing physicians should be dedicated individuals pledged to devoting many hours to the training program. Just to attend a clinic so that the clinic is "covered" by a staff physician is not enough. The staff physician should be prepared to discuss some definite subject as related to the patients being seen. This requires preparation beforehand. In this way, the intern will feel he is getting something out of his training.

By and large, many practicing physicians are too busy to take an active role in a teaching capacity. Many are unqualified to serve as teachers to the developing young doctor. The accrediting boards serve only to evaluate the physical plant as meeting the standards for adequate medical care. They do not evaluate the practicing physicians who will be assuming the role of teacher in the program once it is approved. If this were done, I am sure many presently approved programs would be discontinued.

I, for one, hope to see the internship continued, but unless there is an altered trend in the internship approval system, we may as well discontinue it altogether.

Quentin C. DeHaan, M.D.
Medical Director
Polk County Hospital
Bartow

Fourth Annual Conference
County Medical Society Presidents and Secretaries

January 13-14, 1962
Hotel Robert Meyer
Jacksonville

NEWS-PERSONALS

The Fourth Annual Cardiovascular Seminar sponsored by the Hillsborough County Heart Association of Tampa and the Suncoast Heart Association of St. Petersburg will be held Saturday and Sunday, February 17-18, at the Hawaiian Village Motel in Tampa. Programs will be presented from nine until four o'clock including luncheon panels each day, according to announcement by Dr. Roy F. Saxon Jr. of Tampa. Members of the faculty include Dr. Jesse E. Edwards of St. Paul, Minn.; Drs. Donald B. Effler and Irving H. Page of Cleveland; Drs. Alexander Nadas and Bernard Lown of Boston, and Dr. Tinsley R. Harrison of Birmingham, Ala.

The Midwinter Seminar in Ophthalmology and Otolaryngology has been scheduled for January 28-February 4 at the Americana Hotel in Bal Harbour, Miami Beach. Lecturers in ophthalmology include Drs. A. B. Reese, Byron Smith and Donald M. Shafer of New York City; Dr. Albert E. Sloane of Boston, and Dr. Lorenz E. Zimmerman of Washington.

Post Graduate Cardiac Surgical Colloquia sponsored by the Section of Thoracic and Cardiovascular Surgery and the University of Miami School of Medicine scheduled for January and February include: "Physiologic Aspects of Total Body Perfusion," Dr. John H. Gibbon Jr., Professor and Chairman, Department of Surgery, Jefferson Medical College, January 13; "Perfusion Hypothermia," Dr. Ivan W. Brown Jr., Professor of Surgery, Duke University School of Medicine, January 27; "Auxiliary Circulatory Support," Dr. Dwight E. Harken, Associate Clinical Professor of Surgery, Harvard Medical School, February 10, and "Open Cardiac Correction of Tetralogy of Fallot," Dr. John W. Kirklin, Section of Surgery, Mayo Clinic, February 24. The conferences will be held in Jackson Memorial Hospital.

A Seminar in Obstetrics and Gynecology is being presented by the Department of Obstetrics and Gynecology of the University of Florida College of Medicine in Gainesville January 11-12. The faculty is Dr. Duncan E. Reid, Professor

and Chairman, Department of Obstetrics and Gynecology, Harvard Medical School, Boston, and Dr. Howard C. Taylor Jr., Professor and Chairman, Department of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York City.

Dr. Fred H. Albee Jr. of Daytona Beach has been elected a trustee of the American Association of Medical Assistants.

Drs. G. Dekle Taylor and Max Michael Jr. of Jacksonville participated in the program of the annual meeting of the Georgia Academy of General Practice held the middle of October at Jekyll Island, Ga. Dr. Taylor presented a paper entitled "Office Management of Common Ear Problems," and Dr. Michael discussed the topic "Newer Concepts of Common Viral Illness."

Dr. Harold O. Hallstrand of Miami participated in the panel discussion on "Diagnosis and Treatment of Tumors and Cysts of the Neck, Including Carcinoma of the Thyroid Gland" at the Mid-Atlantic Regional Meeting of the International College of Surgeons held October 12-14 at Atlantic City.

Dr. J. Brown Farrior of Tampa presented an exhibit entitled "Ear Surgery - 1961" at the meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago, October 6-13. In addition, Dr. Farrior gave courses on physiological stapedectomy and tympanoplasty.

Drs. Howard C. Duckett and John J. Fisher of Jacksonville attended the International Congress of Obstetrics and Gynecology and the International Congress of Psychology at Vienna, Austria, during August and September. Dr. Duckett also attended the World Congress of Genetics in Rome.

A Seminar in Pediatric Surgery entitled "Common Surgical Problems in Children" will be presented by the University of Florida College of Medicine in Gainesville January 25-27. Non-surgical conditions affecting surgical decisions in children, pre- and postoperative management of the child, and recent advances in surgical care of infants and children will be discussed by Drs. Tague Chisolm and Robert Ulstrom, University of Minnesota Medical School, Minneapolis; Dr. William Clatworthy, Ohio State University College of Medicine, Columbus; Dr. Floyd Denny, University of North Carolina School of Medicine, Chapel Hill; Dr. Howard Pearson, Naval Medical Research Laboratories, and members of the Departments of Pediatrics and Surgery of the University of Florida College of Medicine.

Dr. S. Allen Clark of Lakeland has been presented a plaque by the First Methodist Church of Lakeland in recognition of his 35 years of service to the church school as a former superintendent and chairman of the Commission on Education.

Dr. William M. Madison Jr. of Jacksonville presented a paper entitled "Cardiac Involvement in the Ehlers-Danlos Syndrome" at the Regional Meeting of the American College of Physicians held at Sea Island, Ga., September 29-October 1.

Dr. Theodore F. Hahn Jr. of Deland was installed as president of the Florida Diabetes Association at the Ninth Annual Meeting held October 19-20 at Miami Beach. Dr. James B. Tobias of St. Petersburg was chosen president-elect, and Dr. George F. Schmitt Jr. of Miami was reelected secretary-treasurer. Serving as members of the Board of Directors for the next year will be Drs. Richard H. Sinden of St. Petersburg; A. Gorman Hills and Kenneth Phillips of Miami; James R. West of Lakeland, and James E. Fulghum of Jacksonville.

Dr. J. Harold Newman of Jacksonville presented a paper entitled "Renal Hypothermia Produced by the Direct Application of Ice" at the annual meeting of the Northeastern Section of the American Urological Association held at Poland Spring, Maine, in October.

Dr. Robert B. Lawson of Miami, Acting Dean and Chairman of the Department of Pediatrics of the University of Miami School of Medicine, has accepted the joint appointment as Chairman of Pediatrics at the Northwestern University School of Medicine and chief of staff of the Children's Memorial Hospital in Chicago effective in February.

The Eighth Annual Central Florida Medical Meeting will be held Saturday, February 3, at the

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Cherry Plaza Hotel in Orlando. Medical and surgical aspects of certain endocrine disorders are to be discussed by the guest speakers which include Dr. Garfield Duncan of Philadelphia; Drs. John Stanbury and Oliver Cope of Boston, and Dr. John Preedy of Atlanta. A golf tournament is scheduled for Thursday afternoon, February 1, at the Orlando Country Club and informal Fireside Conferences the following evening. The meeting will be concluded with a social hour and banquet at which Colonel George Knauf of Cape Canaveral will be principal speaker. Dr. Don C. Robertson of Orlando is chairman of arrangements.

Dr. Ralph Jones Jr. of Miami, Professor and Chairman of the Department of Medicine at the University of Miami School of Medicine, has been awarded the medal of the Pan American Medical Society in recognition of his contribution to fellowship and understanding among scientists in the western hemisphere.

MEETINGS

December

Florida Obstetric and Gynecologic Society, Dec. 3-4, Gault Ocean Mile Hotel, Fort Lauderdale

Florida State Surgical Division, International College of Surgeons, Dec. 1-2, College of Medicine, University of Florida, Gainesville

January

Seminar in Obstetrics and Gynecology, Jan. 11-12, College of Medicine, University of Florida, Gainesville

Conference of County Medical Society Presidents and Secretaries, Jan. 13-14, Hotel Robert Meyer, Jacksonville

Seminar in Pediatric Surgery, Jan. 25-27, College of Medicine, University of Florida, Gainesville

Midwinter Seminar in Ophthalmology and Otolaryngology, Jan. 28-Feb. 4, Hotel Americana, Miami Beach.

February

Eighth Annual Central Florida Medical Meeting, Feb. 1-3, Cherry Plaza Hotel, Orlando

Fourth Annual Cardiovascular Seminar, Feb. 17-18, Hawaiian Village Motel, Tampa



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DEATHS

Andrews, Chadbourne Avery, Tampa; born in Brockton, Mass., on Dec. 12, 1884; College of Physicians and Surgeons of Baltimore (now the University of Maryland), 1909; held an internship and residency at St. Joseph's Hospital in Baltimore; entered the practice of surgery in Tampa in 1912; served as a first lieutenant in the Army during World War I; because of a war injury was obliged to forego surgery and after 1922 devoted full time to dermatology; was chairman of the Procurement and Assignment Board of Hillsborough County during World War II; was a past president of the Hillsborough County Medical Association and of the Southeastern Dermatological Association; was a charter member of the Florida Society of Dermatology and served twice as its president; also held membership in the American Academy of Dermatology, the American Medical Association and the Southern Medical Association; died January 2, aged 76.

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Baber, John Marion Jr., West Palm Beach; born in Farnell, Miss., Mar. 16, 1895; George Washington University School of Medicine, Washington, D. C., 1929; a veteran of World War I and a recipient of the Congressional Certificate of Merit for Selective Service work in World War II; also prominent in the legal profession, he received the LL.B degree at Georgetown University School of Law in 1922 and the LL.M. degree the following year; was admitted to the bar in the District of Columbia in 1923 and that same year to the United States Circuit Court of Appeals for the District of Columbia and the Supreme Court of the United States; was an instructor of commercial law and English at the Catholic University in Washington in 1922 and 1923 while serving as an attorney with the Department of Justice; was admitted to the practice of medicine in the District of Columbia in 1929 and practiced in Washington as an otolaryngologist and specialist in legal medicine; served as instructor in anatomy and physiology at Emergency Hospital School of Nursing from 1930 to 1935 and instructor in anatomy at Georgetown University School of Medicine from 1933 to 1935; engaged in general practice in West Palm Beach since 1946; was a member of the Palm Beach County Medical Society, the American Medical Association, the Southern Medical Association and the American Board of Legal Medicine, and president of the Palm Beach County chapter of the Florida Academy of General Practice; died June 14, aged 66.

Croft, George William, Jacksonville; born in Aiken, S. C., in 1907; Medical College of South Carolina, Charleston, 1932; served a residency at Baker Sanitarium, Charleston, and did graduate work at Roper Hospital, Charleston, and Cook County Graduate School, Chicago; had practiced surgery in Jacksonville since 1933; held membership in the Duval County Medical Society, the American Medical Association and the Southeastern Surgical Congress; died Mar. 3, aged 53, after an illnes of several months.

Glenn, Francis William, Coral Gables; born in Maryland in 1904; Temple University School of Medicine, Philadelphia, 1933; served a residency in orthopedic surgery at the Shriners Hospital for Crippled Children in Philadelphia from 1935 to 1938; practiced orthopedic surgery in Coral Gables for 22 years; was a mem-

ber of the Dade County Medical Association, the American Medical Association, the American Academy of Orthopaedic Surgeons, the International College of Surgeons, and the American Fracture Association of which he was Regional Vice President and a member of the Board of Governors; served on the faculty of the University of Miami School of Medicine; died February 27, aged 57.

Henley, Charles Frederick, Jacksonville; born in Prairie, Miss., in 1905; University of Tennessee College of Medicine, Memphis, 1930; served an internship at a Memphis hospital and at St. Luke's Hospital, Jacksonville; had practiced in Jacksonville since 1931; was a member of the Duval County Medical Society, serving as its president in 1950, the American Medical Association and the Southern Medical Association, and was a fellow of the American Academy of General Practice; had served as treasurer and as chairman of the Florida Medical Committee for Better Government; died October 29, aged 56, following a heart attack.

Hudson, Howard Sampson, St. Petersburg; born in Pleasantville, N. J., in 1912; Hahnemann Medical College, Philadelphia, 1936; interned at St. Luke's Children's Hospital in Philadelphia; was a veteran of World War II; practiced in Ocean City, N. J., from 1946 to 1958; joined the staff of the Pinellas County Health Department in 1958, as epidemiologist; was a member of the Pinellas County Medical Society and the American Medical Association; died June 15, aged 49.

Ingram, Hollis Carlyle, Orlando; born in Zumbro Falls, Minn., in 1905 and moved to Orlando in 1920; Tulane University School of Medicine, New Orleans, 1934; served an internship at Wesley Hospital, Wichita, Kan., and a residency in Eye, Ear, Nose and Throat at Charity Hospital of Louisiana, New Orleans; in 1937, entered the private practice of medicine in Orlando in association with his father, the late Dr. L. C. Ingram; during World War II served in the Army Air Force from 1942 to 1945; was a past president of the Orange County Medical Society and a member of the American Medical Association, the Florida Society of Ophthalmology and Otolaryngology, the American Academy of Ophthalmology and Otolaryngology, and the Academy International of Medicine, and a diplo-

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Gynecology
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Maxwell M. Wintrobe, M. D., Salt Lake City, Utah
Internal Medicine
Bernard J. Alpers, M. D., Philadelphia, Pa.
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Ralph C. Benson, M. D., Portland, Ore.
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Ophthalmology
John H. Moe, M. D., Minneapolis, Minn.
Orthopedic Surgery
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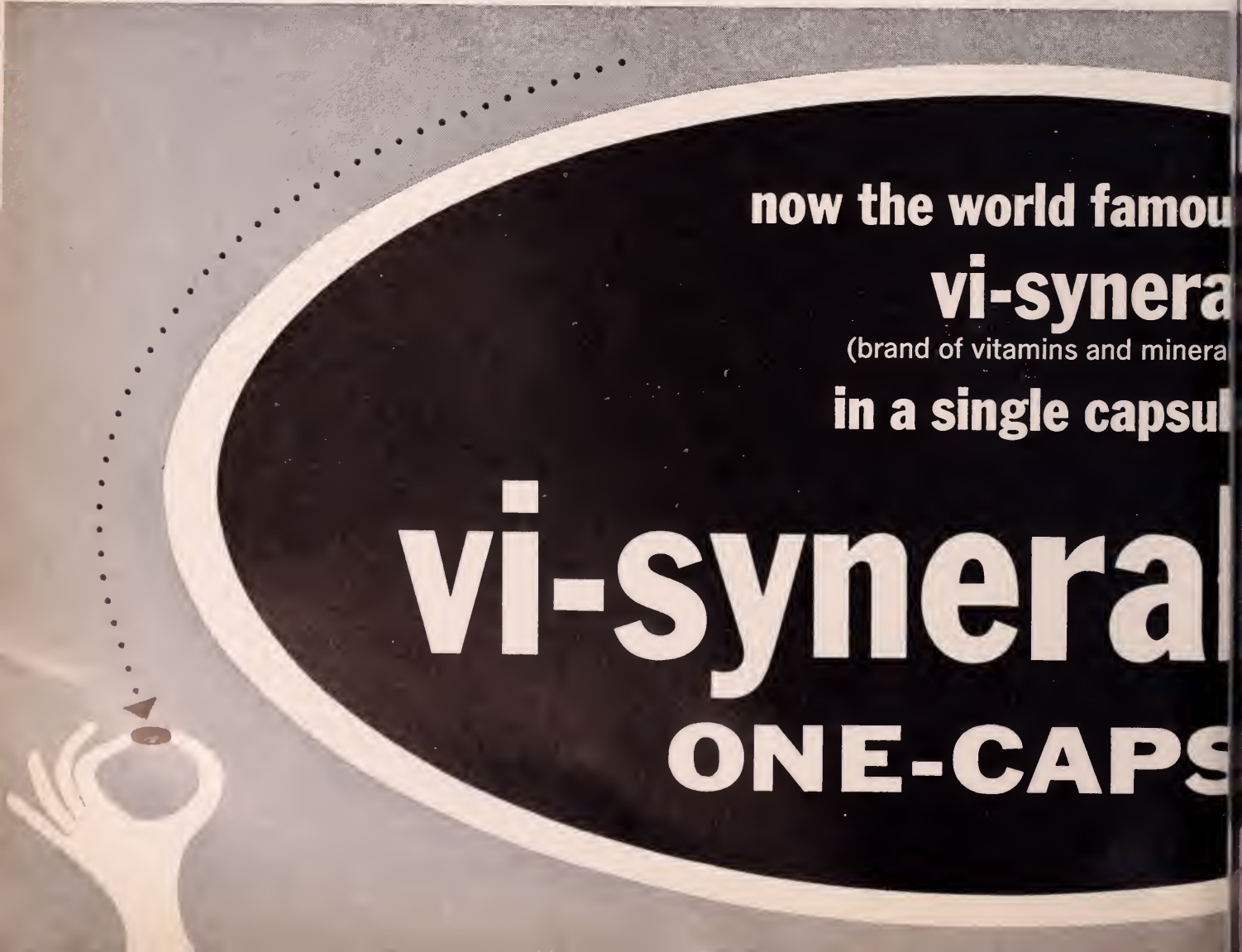
mate of the American Board of Ophthalmology; served for years on the Medical Advisory Committee to the Florida Council for the Blind; died June 11, aged 55.

Jones, Frank Curtis, Archer; born in Saluria, Ala., in 1888; Atlanta School of Medicine, Atlanta, Ga., 1915; interned at Duval County Hospital, Jacksonville, and served a residency at St. Luke's Hospital, Jacksonville, where he was assistant superintendent from 1917 to 1918; headed the first venereal disease clinic in Florida at Jacksonville and continued in private practice there from 1918 to 1938; practiced in Archer thereafter and served as mayor and municipal judge in 1946; was a member of the Alachua County Medical Society and the American Medical Association; died August 3, aged 73, after a lengthy illness.

Jones, Oliver Lee, West Palm Beach; born in Essex County, Virginia, on Aug. 16, 1900; Medical College of Virginia, Richmond, 1927; interned at Lewis-Gale Hospital, Roanoke, Va., and at Norfolk General Hospital, Norfolk, Va.; served with the Veterans Administration during World War II; in 1946 entered general practice in West Palm Beach, where he had served as city physician since 1953 and for a time was part time county physician; was a member of the Palm Beach County Medical Society, the American Medical Association, the Southern Medical Association, the American Academy of General Practice and the American Geriatric Society; died June 20, aged 60.

Kendall, William Eugene, St. Petersburg; born in Mason City, Ill., in 1884; Chicago College of Medicine, Chicago, 1913; was a veteran of World Wars I and II; came to St. Petersburg from Chicago in 1939, where he engaged in the practice of internal medicine; was a member of the Pinellas County Medical Society and the American Medical Association and a life member of the American College of Physicians; died Nov. 17, 1960, aged 76.

Kinzie, Joseph Lee, Lake Wales; born in Roanoke, Va., on Mar. 1, 1904; Medical College of Virginia, Richmond, 1933; practiced in Salem, Va., for 10 years; served as a captain in the Army during World War II; then located in Lake

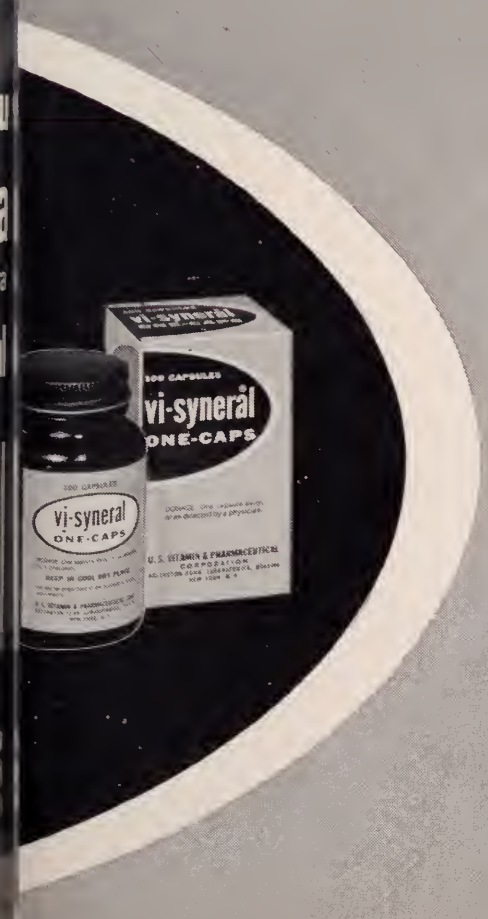


Wales; was a member of the Polk County Medical Association and the American Medical Association, and a past president of the Medical staff of the Lake Wales Hospital; died February 10, aged 56.

Lawrence, Howard Foster, St. Petersburg; born in Falmouth, Mass., in 1882; New York University College of Medicine, 1904; served in the United States Navy for 38 years and was appointed captain in the Navy Medical Corps in 1931; was a veteran of World Wars I and II and also a medical officer in several Naval districts; came to St. Petersburg from Philadelphia in 1949 and engaged in the practice of dermatology; was a member of the Pinellas County Medical Society and the American Medical Association and was certified by the American Board of Dermatology; died August 26, aged 79.

Montgomery, Kenneth E., West Palm Beach; born in 1892; Louisville Medical College, Louisville, Ky., 1917; served overseas as an officer in the Medical Corps of the United States Army in World War I; was a member of the American Urological Association for 35 years and practiced his specialty in West Palm Beach from 1935 until his retirement; was a member of the Palm Beach County Medical Society and the American Medical Association; died Sept. 19, 1960, aged 68, following a long illness.

Rothrock, David R., Miami; born in Milton, Pa., on Mar. 24, 1920; Hahnemann Medical College, Philadelphia, and was graduated from The College of Physicians and Surgeons, Boston, 1945; interned at Vassar Brothers Hospital, Poughkeepsie, N. Y., and served a two year residency in psychiatry at Harlem Valley State Hospital, Wingdale, N. Y.; was staff psychiatrist at Chattahoochee State Hospital from 1947 to 1952; then entered the United States Army serving for two years as a captain at Brooke General Hospital in Texas and later in Puerto Rico; thereafter specialized in general medicine with a subspecialty of psychiatry and neurology and was staff physician at the Miami Sanitarium; held membership in the American Medical Association and the American Psychiatric Association; died July 10, aged 42, following a heart attack.



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Sasso, Robert Michael, Lake City; born in Mount Vernon, N. Y., May 21, 1913; Georgetown University School of Medicine, Washington, D. C., 1939; interned at St. Joseph's Hospital, Yonkers, N. Y.; entered the Veterans Administration Medical Service in 1941; served at the Veterans Hospital at Lake City during World War II with the rank of captain in the Medical Corps of the Army; entered private practice in Westchester, N. Y., after the war; later returned to the Veterans Administration service at the Veterans Hospital at Lake City during World War eventually engaged in private practice there; was a member and had served as an officer of the Columbia County Medical Society and several times served as a delegate or an alternate in the House of Delegates of the Florida Medical Association; held membership in the American Medical Association and the Suwannee River Valley Medical Society; was responsible for the Columbia County unit of the Northeast Florida Heart Association and was its first president; died September 11, aged 48, of a heart attack.

Sheldon, N. Alice Strahan, Darien, Conn.; born in Newark, N. J., in 1928; Cornell University Medical College, New York, 1954; engaged in the general practice of medicine in Miami; died May 2, aged 32, of accidental drowning at sea.

Sinnott, Richard F., Fort Pierce; born in Chicago in 1916; Stritch School of Medicine of Loyola University, Chicago, 1942; was a veteran of World War II, serving as a major in the Army Medical Corps in the South Pacific; had engaged in general practice in Fort Pierce since 1947; was a member and past president of the St. Lucie-Okeechobee-Martin County Medical Society and represented that society in the House of Delegates of the Florida Medical Association; was a member of the Florida Academy of General Practice and of its Board of Directors, and a member of the American Medical Association; died May 19, aged 45, of a heart attack.

Taylor, Willard Mitchell, Fort Lauderdale; born in Monroeville, Ind., Dec. 18, 1907; Indiana University School of Medicine, Indianapolis, 1940; interned at Methodist Hospital, Indianapolis; practiced in Crawfordsville, Ind., for 10 years before locating in Fort Lauderdale in 1952; was a member of the Broward County Medical

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References: 1. Curran, T. R., and Phelps, D. K.: Am. Pract. & Dig. Treat. *11:* 617, 1960. 2. Levy, S.: J.A.M.A. *153:* 1260, 1953. 3. Connolly, R.: W. Va. Med. J. *56:* 263, 1960.



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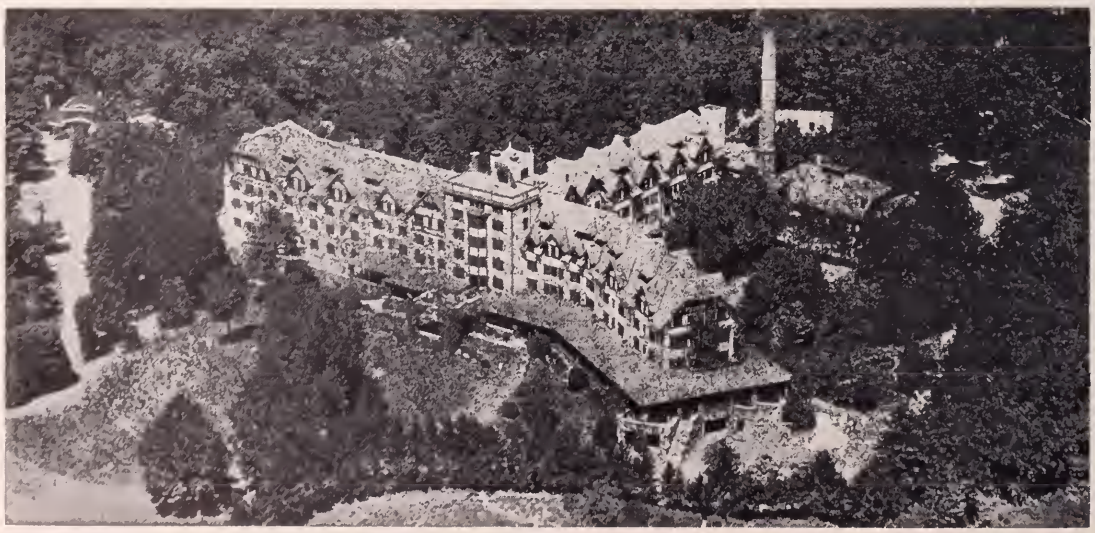
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Association, the American Medical Association and the American Academy of General Practice; died August 30, aged 53, of coronary thrombosis.

Trombley, Joseph Jerome Jr., Pompano Beach; born in Detroit, Mich., June 20, 1901; University of Michigan Medical School, Ann Arbor, 1925; interned at Harper Hospital and then spent two years as a junior associate before entering surgical practice in Detroit; entered general practice in Pompano Beach in 1957 and was active in the organization of North District Hospital; was a member of the Broward County Medical Association and the American Medical Association; died July 16, aged 60.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical Societies.

Active

Addington, William F., Cocoa Beach
Allison, Gordon G., Clewiston
Blank, Richard H., Tampa
Bourland, William L., Indialantic
Brewer, Harold D., Plant City
Crevasse, Lamar E. Jr., Gainesville
Ferber, Carl J., Fort Myers
Ferguson, Robert W., Fort Myers
Harris, Jeff W., Tampa
Kahana, Shirley E., Tampa
Lawyer, Howard A., Pensacola
Lipsey, John C., Pensacola
Newcomb, Thomas F., Gainesville
Panaro, Robert J., Pensacola
Polizo, Dimitri C., Pensacola
Pollock, Adrian Q., Fort Myers
Serrano, M. Edward, Brandon
Sharp, Thomas B. Jr., Pensacola
Shuttleworth, John G., Pensacola
Travis, David M., Gainesville
Williams, Robert L., Gainesville

Associate

Andersen, Thorkild W., Gainesville
Anderson, Richard M., Gainesville
Arean, Victor M., Gainesville
Aron, Jack D., Hollywood
Blalock, John C. Jr., Winter Park
Brede, Edward H. III, Fort Lauderdale
Clement, Stephen P. Jr., Sarasota
Coleman, Hyron E. (Col.), DeLand
Creighton, Francis S., Fort Lauderdale
Jelks, Allen N., Sarasota
Jelks, Mary L., Sarasota
Kaufman, Raymond E., Lake Worth
Keen, Ralph, West Palm Beach
Klorfein, Elliott H., Gainesville
Mosco, James A., Ormond Beach
Noble, Charles R., Orlando
Rushton, Francis E., Sarasota



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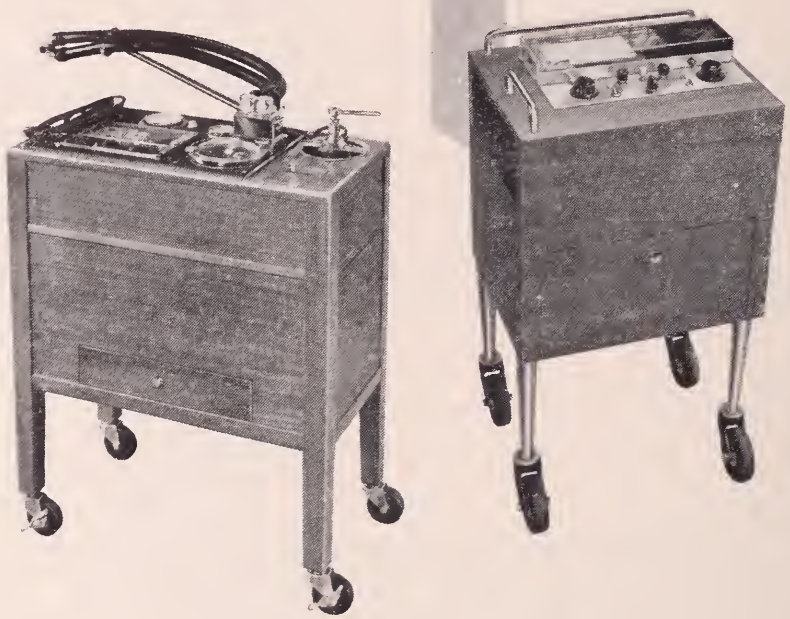
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BOOK REVIEWS

Infectious Diseases of Children. *By Saul Krugman, M.D., and Robert Ward, M.D.* Ed. 2. Pp. 398. Illus. 55 with 7 color plates. Price $13.00. St. Louis, The C. V. Mosby Company, 1960.

The 31 chapters comprising this pediatric medical text have been syntactically arranged with the adroitness of masters in medical composition. The authors deserve commendation on the style simplicity yet thorough dexterity in scaffolding the construction of this scalene subject. Advertence to the virus has been responsible for many "modern" texts being shelved into a depository for relics. The authors, cognizant of such, felt the necessity of a second edition in order that the student be versed in the rapidly changing world of children's infectious diseases. Not only have the writers been appraisers of the virgin viral infections, but also have repatterned the antiquated bastard bacterial diseases. The exanthemata in this volume are presented comparatively with schematic drawings and graphs which should be most pleasing to the reader. Diseases of rickettsial origin are discussed in detail, but for the sake of simplification in distinguishing the disease characteristics they are placed in table form. A short but attractive chapter is dedicated to rabies. This rather rare but important emergency is little understood by the lay people, and so a knowledge of its management is worth the chapter. Acute respiratory infections can be confusing, and the question usually is "to treat or not to treat." The chapter apportioned to these maladies will assist the reader in organizing his thoughts as well as his armaments of therapeusis. Summarily, the publication is elegantly terse, unquestionably instructive, and it is recommended to those interested in diseases of childhood.

Clifford C. Snyder, M.D.

Ciba Foundation Symposium on Haemopoiesis: *Cell Production and its Regulation.* Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 490. Illus. 107. Price, $11.00. Boston, Little, Brown and Company, 1960.

This volume of the important Ciba Foundation series contains 16 interesting papers and the even more interesting discussions upon them presented by 27 research workers in the field of hematology in February 1960 at a conference held at the suggestion of Prof. J. M. Yoffey, "who thought that quantitative aspects of blood cell production could profitably be discussed by experts in hemopoiesis, however many other hematological conferences might have been held in recent years." Every known aspect of hemopoiesis was studied from all possible angles, and the papers carried extensive bibliographic reference lists. The discussions were so lively as to border at times on the emotional and the differences of opinion among the scientists were very strong and definite in many instances, particularly in the various discussions over the possibility of an "initial" stem cell being an immature large lymphocyte. This was called by Professor Yoffey ". . . perhaps the most exciting detective story in the whole of modern cytology." He related how at a previous scientific meeting he "did literally see one anatomist foam at the mouth when it was suggested that the lymphocyte was not a multipotential cell."

And who said scientists are cold fish?

Carlos P. Lamar, M.D.

Ciba Foundation Symposium on Congenital Malformations. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Cecilia M. O'Connor, B.Sc. Pp. 308. Illus. 91. Price $9.00. Boston, Little, Brown and Company, 1960.

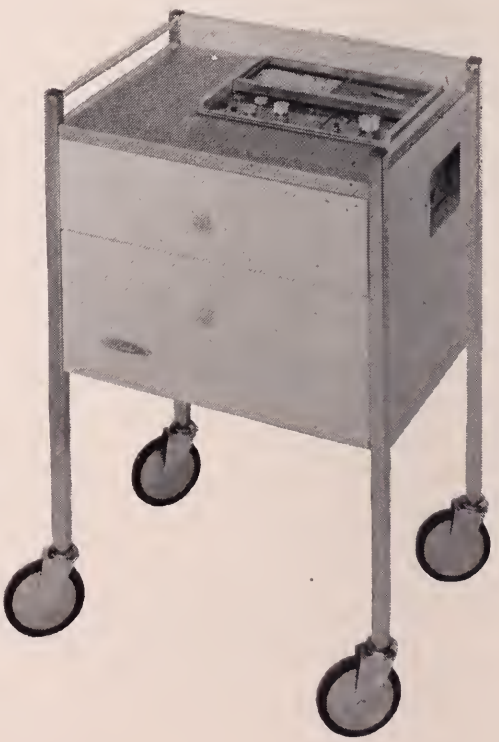
This symposium, as others sponsored by the Ciba Foundation, is the usual excellent presentation dedicated

(Continued on page 587)

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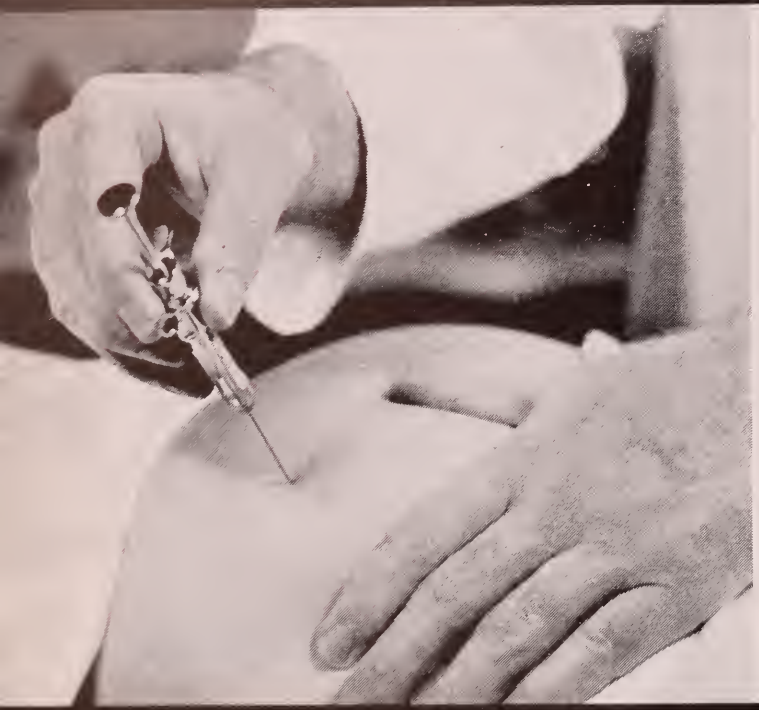
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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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(Continued from page 582)

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Clifford C. Snyder, M.D.

Handbook of Medical Treatment. By Milton J. Chatton, M.D., Sheldon Margen, M.A., M.D., and Henry Brainerd, M.D. Ed. 7. Pp. 572. Price, $3.50. Los Altos, Calif., Lange Medical Publications, 1960.

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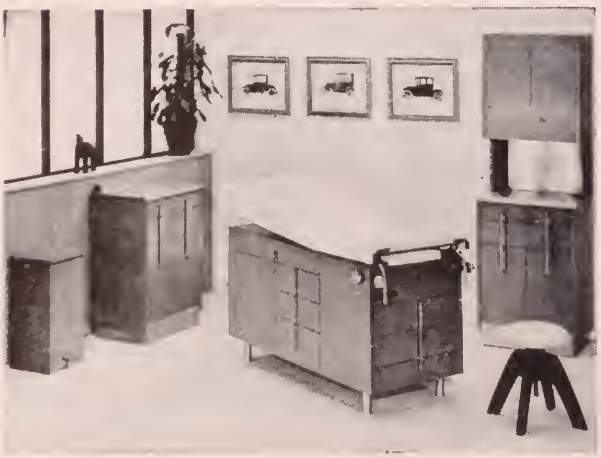
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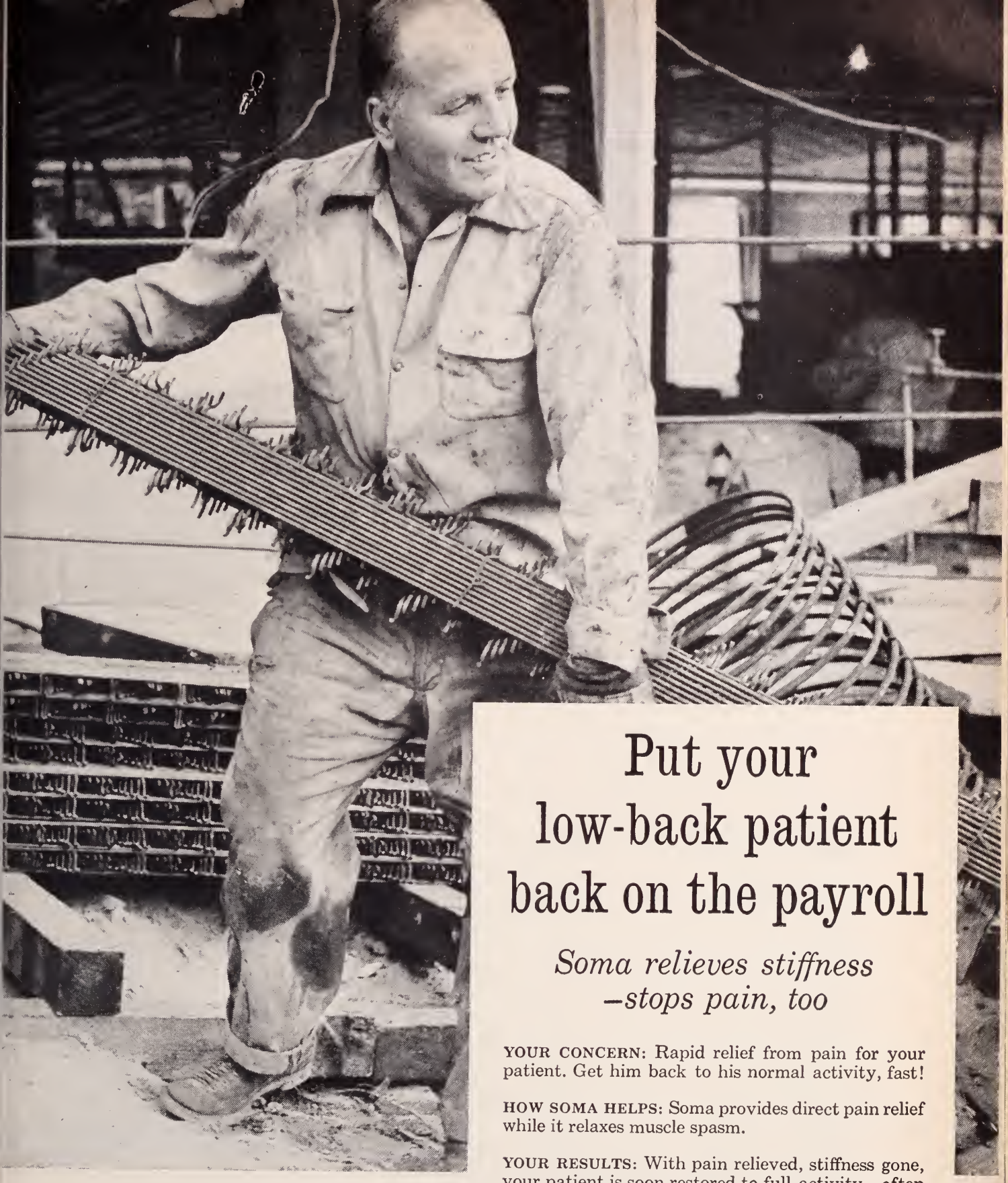
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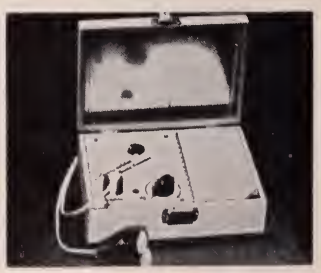


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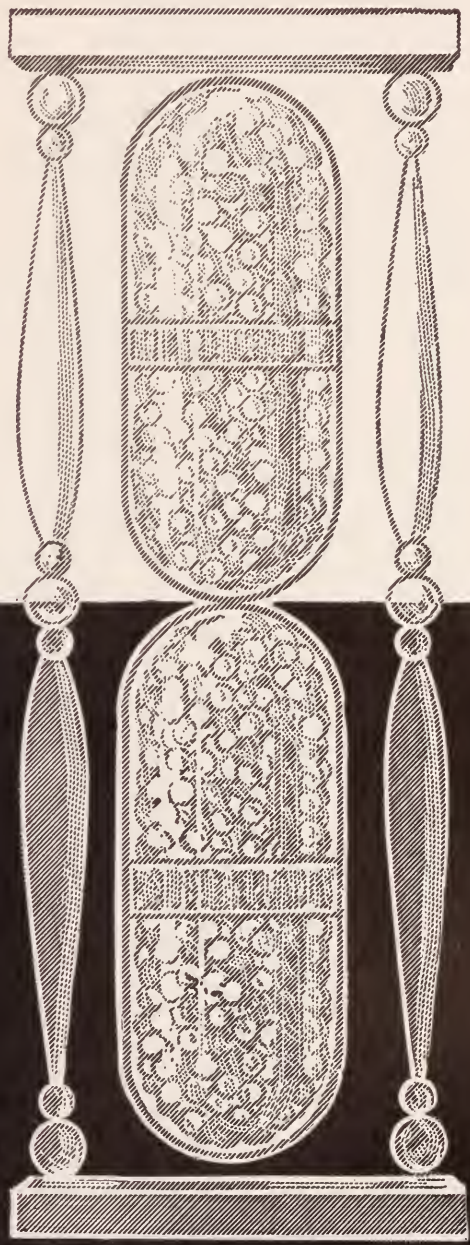
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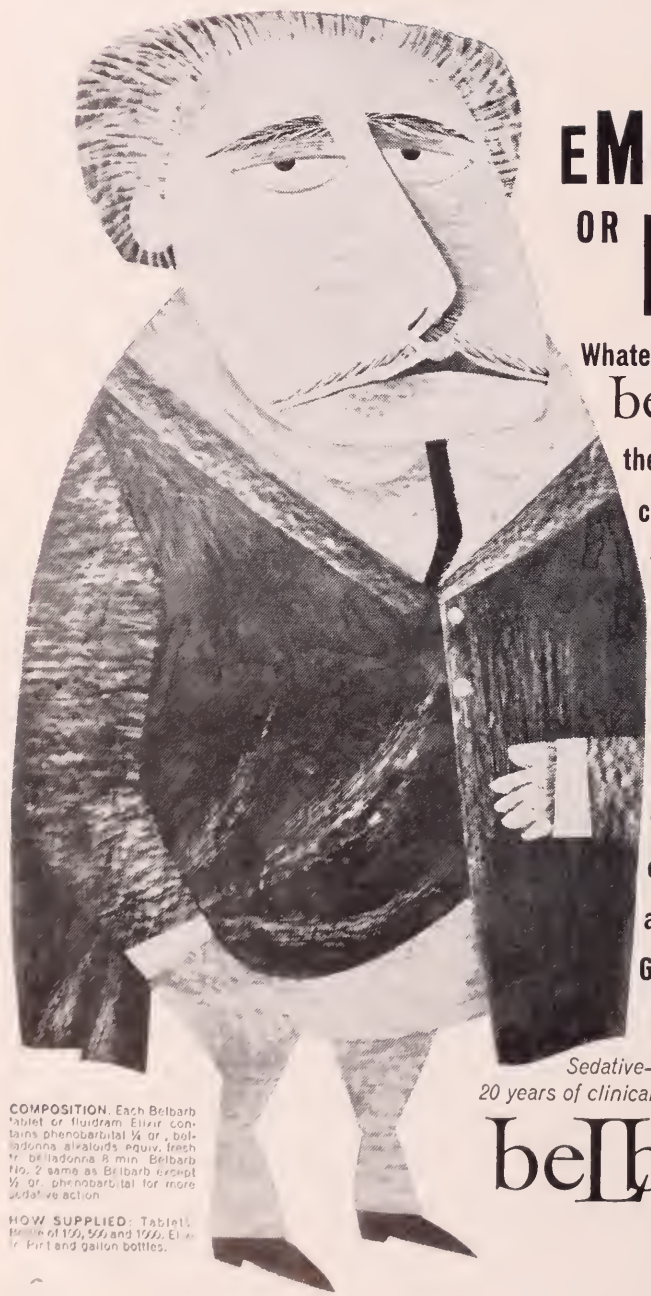
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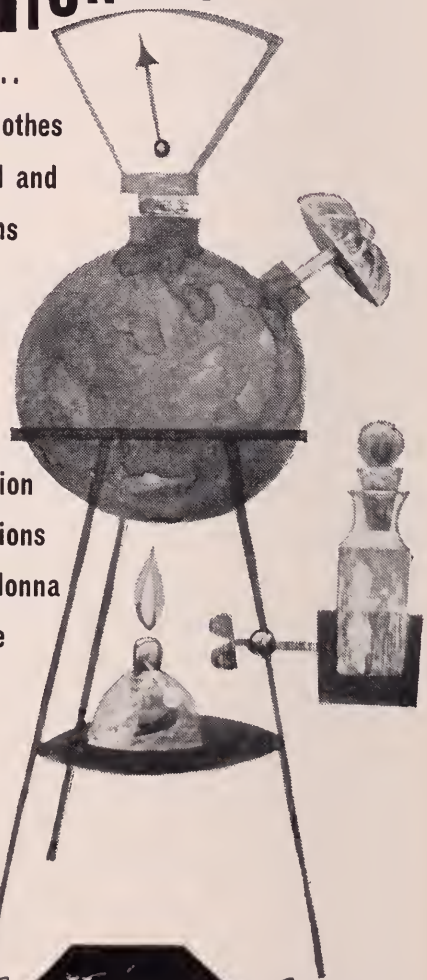
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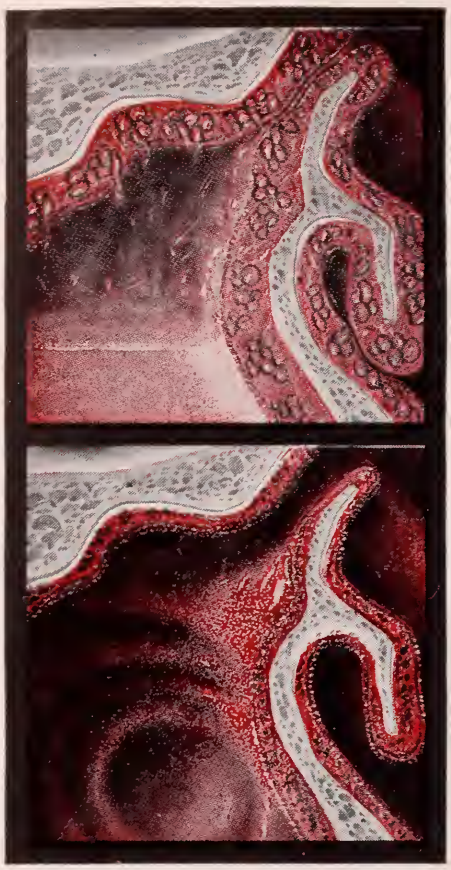
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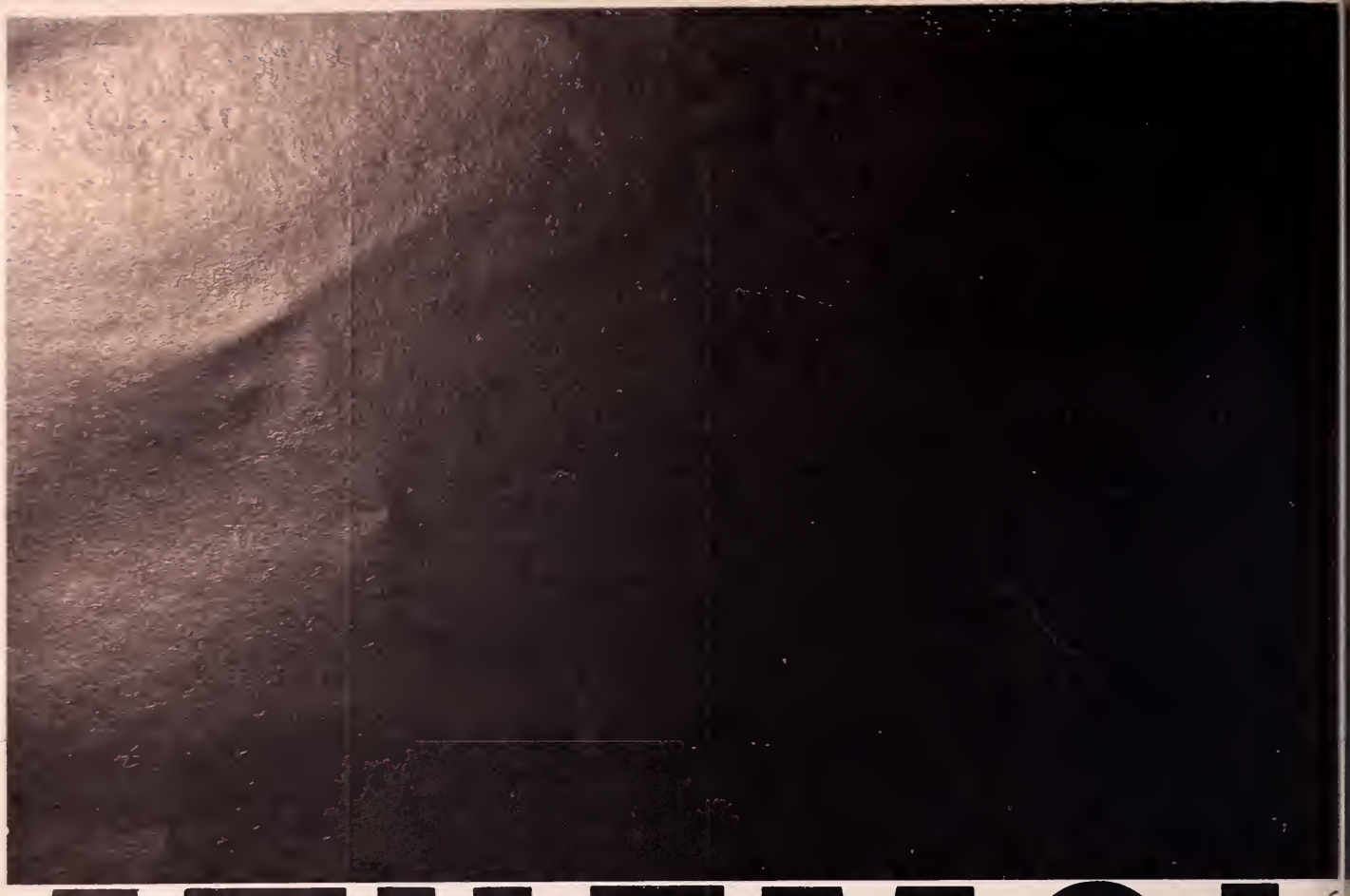
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* *Bradford, Gilchrist, Union*					
Bay	John J. Hollomon, Panama City	A. Ralph Monaco, Panama City	1st Tues.	1	71
Brevard	Willard H. H. Bennett, Titusville	Frederick H. Lucas, Cocoa Beach	1st Tues.	0	31
Broward	W. Dotson Wells, Ft. Lauderdale	Richard A. Martin, Ft. Lauderdale	4th Tues.	58	285
Charlotte	Carl N. Reilly, Punta Gorda	Stephen R. Roddy, Punta Gorda	2nd Tues.		7
Clay	William A. Mulford, Green Cove Spgs.	Joseph G. Ritch Jr., Orange Park			5
Collier	William J. Bailey, Naples	Ethel H. Trygstad, Naples	4th Tues.		13
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		13
* *Baker*					
Dade	Willard L. Fitzgerald, Miami	George W. Robertson III, Miami	1st Tues.	135	1116
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		13
Duval	Sidney Stillman, Jacksonville	Robert J. Brown, Jacksonville	1st Tues.	10	357
Escambia	P. G. Batson Jr., Pensacola	Vernon L. Smith, Pensacola	2nd Tues.	3	125
Franklin-Gulf	William F. Wager, Port St. Joe	Henry I. Langston, Tallahassee	Last Wed.		8
Highlands	Samuel A. King, Avon Park	C. Brooks Henderson, Avon Park	3d Mon.	3	15
Hillsborough	Herbert B. Lott, Tampa	Frank A. Massari, Tampa	1st Tues.	2	278
Indian River	Phil D. Morgan, Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	16
Jackson-Calhoun	Terry Bird, Blountstown	Francis M. Watson, Marianna	Quarterly		16
Lake	Lawton F. Douglass, Umatilla	Raymond A. Debo, Eustis	1st Wed.	4	36
Lee-Hendry	Jack C. W. Warnock, Ft. Myers	Richard W. Plummer, Ft. Myers	3rd Mon.		44
Leon-Gadsden-Liberty-Wakulla-Jefferson	Nelson H. Kraeft, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	6	83
Madison	Julian M. Durant, Madison	A. Franklin Harrison, Madison	1st Tues.	2	6
Manatee	Warren G. Darty, Palmetto	C. Sumner Quimby, Bradenton	2nd Tues.	1	44
Marion	Herbert M. Webb Jr., Ocala	Edwin H. Updike II, Ocala	3rd Tues.	2	36
* *Levy*					
Monroe	William R. Ploss, Key West	Joseph L. G. Lester Jr., Key West	1st Thurs.	1	19
Nassau	Henry B. Dickens Jr., Fernandina Bch.	John B. Britton, Fernandina Beach	1st Thurs.	3	10
Orange	Norman F. Coulter, Orlando	Truett H. Frazier, Orlando	3rd Wed.	36	245
* *Osceola*					
Palm Beach	William H. Proctor, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	39	204
Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	1	22
* *Sumter*					
Pinellas	Edward L. Cole Jr., St. Petersburg	William J. Dean, St. Petersburg	1st Mon.	17	314
Polk	John E. Daughtrey, Lakeland	Albert G. King Jr., Lakeland	2nd Wed.	9	142
Putnam	Walter W. Weigel, Palatka	James R. Sayers, Palatka	2nd Tues.		16
St. Johns	Reddin Britt, St. Augustine	Frank J. LaRosa, St. Augustine	3rd Tues.		19
St. Lucie-Okeechobee-Martin	John D. Browning, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.		29
Sarasota	George A. Bishopric, Sarasota	Harry O. Specht, Sarasota	2nd Tues.	19	87
Seminole	Clyde F. B. Smith, Sanford	George H. Starke (Col.), Sanford	2nd Tues.		20
Suwannee-Hamilton-Lafayette	Hugo F. Sotolongo, Live Oak	William P. Blackmon, Jasper	1st Sat.		7
Taylor	John A. Dyal Jr., Perry	John A. Dyal Jr. (Acting), Perry	Last Fri.		7
* *Dixie*					
Volusia	C. Robert DeArmas, Daytona Beach	Thomas W. Ayres, Daytona Beach	2nd Tues.	10	100
* *Flagler*					
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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

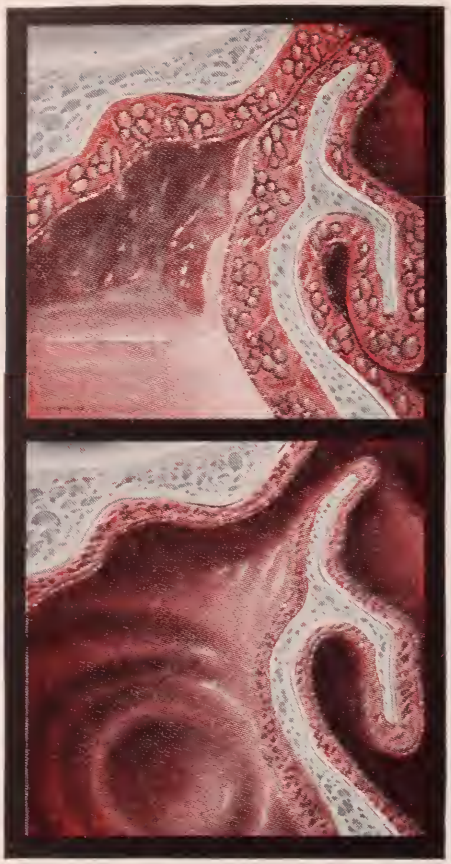
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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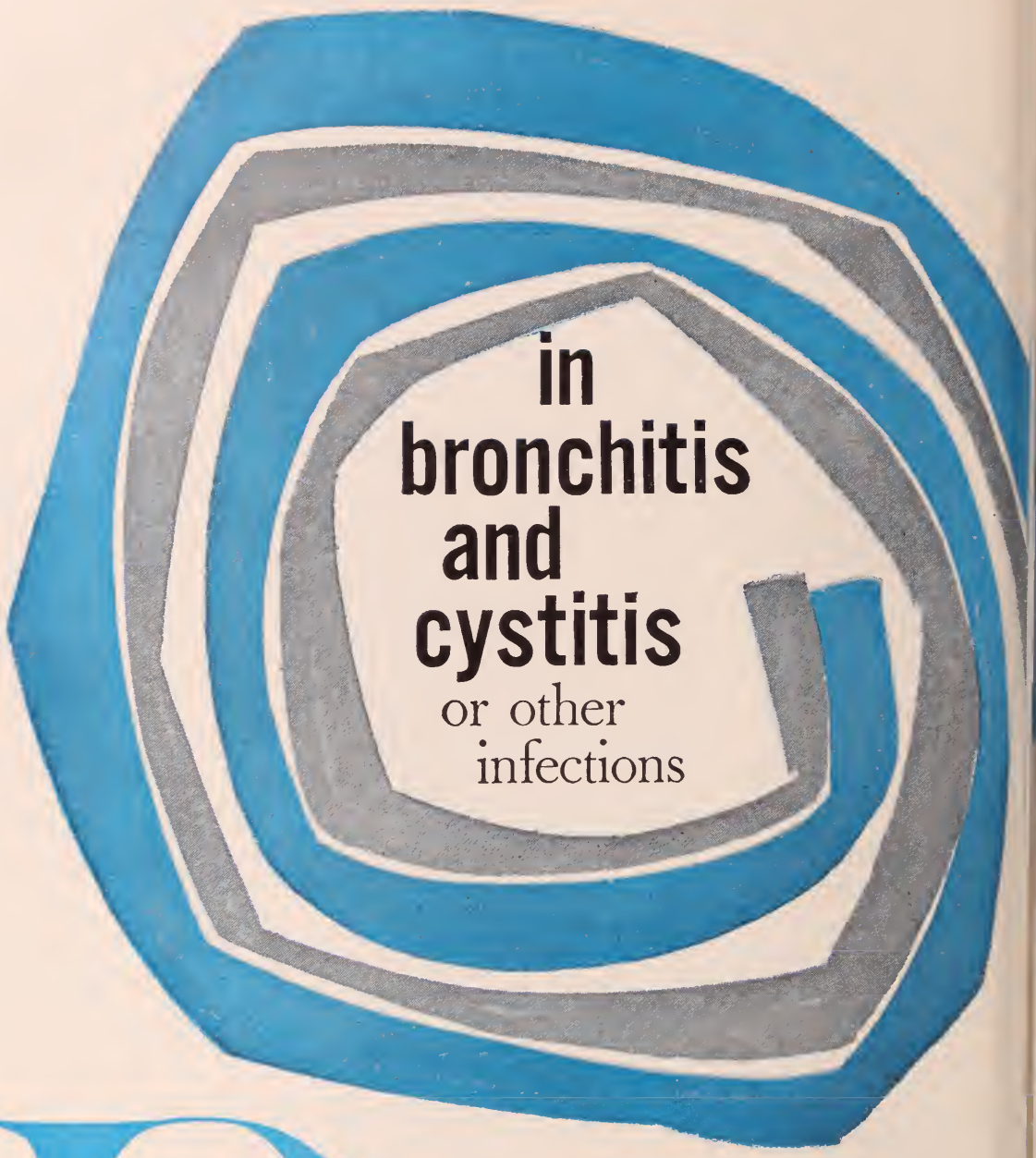
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Because the SEGO DIET PLAN from Pet Milk Company has unique advantages ordinary diets lack:

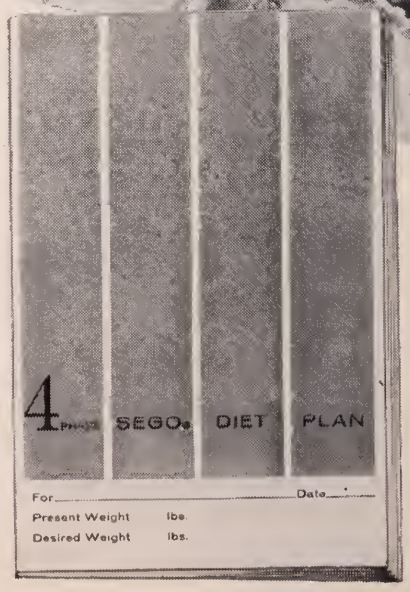
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"SEGO"—Reg. U. S. Pat. Off. Copr., 1961, Pet Milk Co.



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the last Optilets® Filmtab® would still be good

Actually, doctor, labeled potency will last a much longer time. While we would never recommend by-the-year dosage of a therapeutic nutritional, this does illustrate the unusual stability of Optilets.

The reason, of course, is Filmtab coating. Unlike previous sugar coatings, no water is needed for application. This virtually eliminates chances of moisture degradation.

Greater stability, however, is just one of Optilets advantages. Without sugar's bulk, we can make tablets up to 30% smaller in size. Coatings are less brittle, and tablets less apt to chip or break. As Filmtab coatings are no more than paper-thin, nutrients are more readily available. Yet, patients are protected from vitamin odors and after-tastes.

While stability is important and easy administration an advantage, ingredients are, of course, the main criteria for any nutritional. Please check the Optilets formulas, doctor. We think you'll find them a good choice for your patients.

ABBOTT LABORATORIES NORTH CHICAGO, ILLINOIS

Optilets

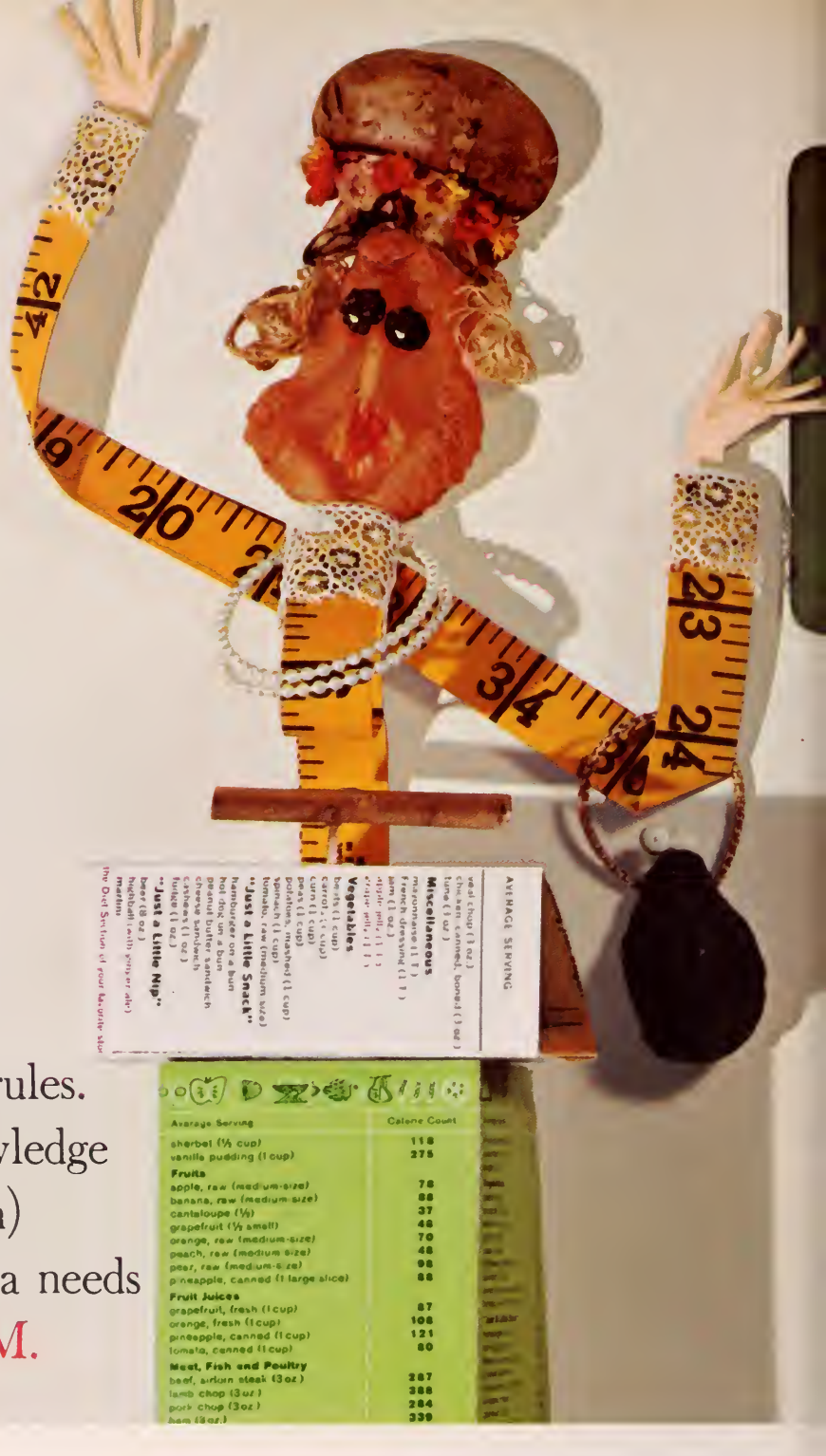
Each Filmtab represents:

Vitamin A	7.5 mg. (25,000 units)
Vitamin D	25 mcg. (1000 units)
Thiamine Hydrochloride	10 mg.
Riboflavin	5 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
Cobalamin (Vitamin B_{12})	6 mcg.
Calcium Pantothenate	20 mg.
Ascorbic Acid	200 mg.

Optilets-M®

Each Filmtab represents all the vitamins of Optilets plus the following:

Iron (as sulfate)	10 mg.
Copper (as sulfate)	1 mg.
Iodine (as calcium iodate)	0.15 mg.
Cobalt (as sulfate)	0.1 mg.
Manganese (as sulfate)	1 mg.
Magnesium (as oxide)	5 mg.
Zinc (as sulfate)	1.5 mg.
Molybdenum (as sodium molybdate)	0.2 mg.



Her position on nutrition
Is taught in all the schools.
She's an oracle for others,
Yet, the first to break the rules.
While a mine of diet knowledge
(And, each lecture is a gem)
Poor Ramona from Pomona needs
some DAYALETS with M.



Likes, dislikes, and time schedules never interfere with her lectures, doctor, just her diet. She could live in a grocery store and still eat poorly. While Dayalets-M can't replace self-discipline, it can help insure optimal nutrition. Tablets are tiny, potent, and Filmtab-coated. Patients like taking them.

Filmtab® DAYALETS-M®...*essential vitamins plus 8 minerals in the most compact tablet of its kind*

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PAIN
AND FEVER
OF COLDS
GRIPPE
SINUSITIS
INFLUENZA



HASAMAL®

(Analgesic-Antipyretic-Sedative)

- **Relieves pain and tension**
- **Reduces fever**
- **Stops excessive nasal secretions**
- **Without unwanted diaphoresis**

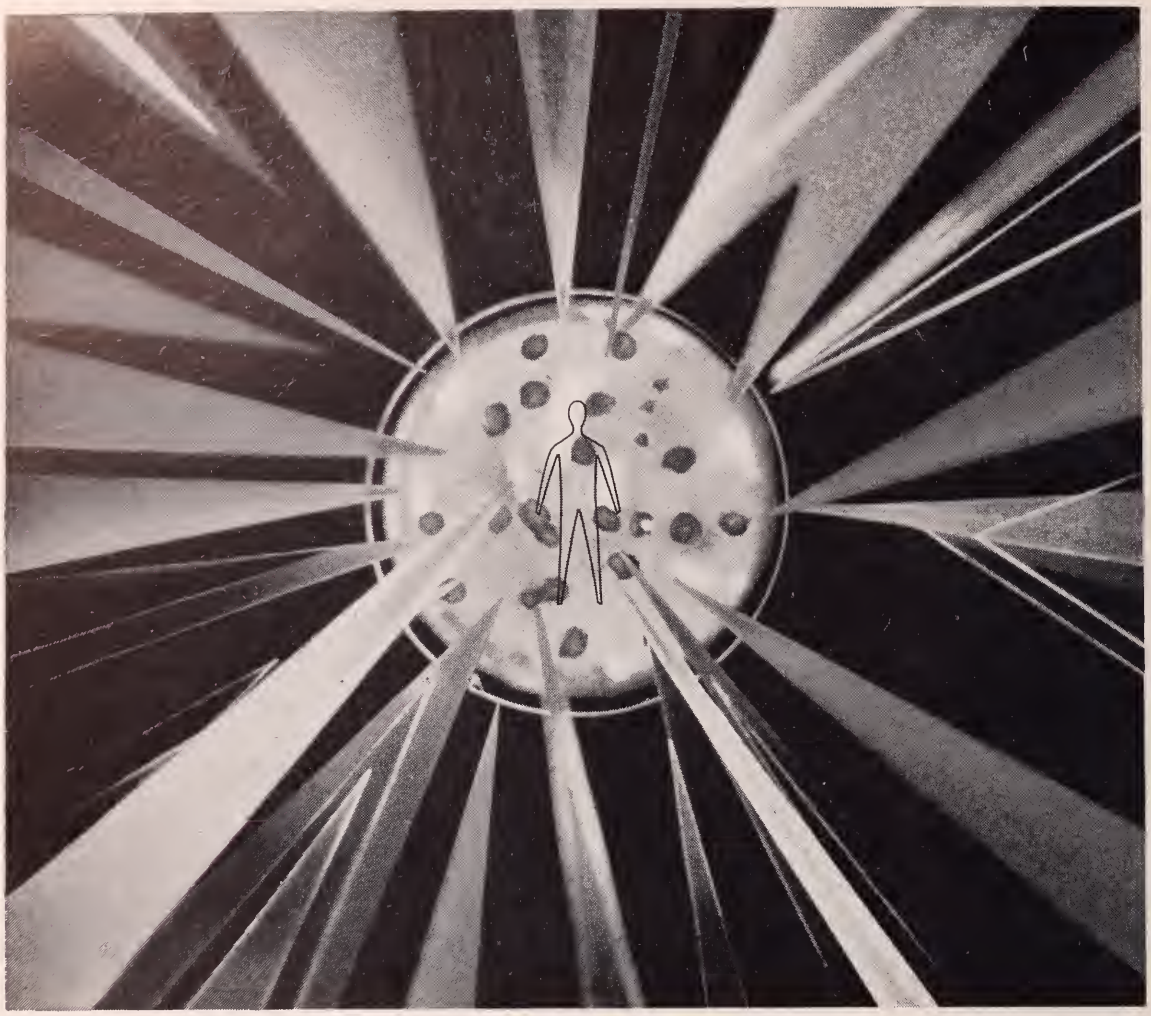
Hasamal, with mild sedation, effectively relieves malaise and discomfort associated with acute infectious disease, such as colds, grippe, sinusitis, tonsillitis, and for earache, headache, and pain of arthritis, neuritis, neuralgia, dysmenorrhea, etc.

Where pain of increased intensity occurs, HASACODE, containing ¼ gr. codeine phosphate, and HASACODE "STRONG," containing ½ gr. codeine phosphate, provide prompt, effective relief.

Composition: HASAMAL: Each tablet or capsule contains: Acetylsalicylic acid, 2½ gr., acetophenetidin, 2½ gr., phenobarbital, ¼ gr., and hyoscyamus alkaloids, .0337 mg. HASACODE combines the same formula as Hasamal with ¼ gr. codeine phosphate, and HASACODE "STRONG" ½ gr. codeine phosphate.

Dosage: Hasamal: One or two tablets or capsules every 3 to 4 hours. **Hasacode:** One or two tablets every 3 or 4 hours; not more than 8 tablets should be taken in 24 hours. **Warning:** Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

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Why do we say Mysteclin-F is decisive in infection?

because... it contains phosphate-potentiated tetracycline
for prompt, dependable broad spectrum antibacterial action.

because... it contains Fungizone, the antifungal antibiotic,
to prevent monilial overgrowth in the gastrointestinal tract.

Mysteclin-F resolves many respiratory, genitourinary and gastrointestinal infections—as well as such other conditions as cellulitis, bacterial endocarditis, furunculosis, otitis media, peritonitis, and septicemia. It combats a truly wide range of pathogenic organisms: gram-positive and gram-negative bacteria, spirochetes, rickettsias, viruses of the psittacosis-lymphogranuloma-trachoma group.

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'Mysteclin'®, 'Sumycin'® and 'Fungizone'® are Squibb trademarks.

Mysteclin-F

Squibb Phosphate-Potentiated Tetracycline (SUMYCIN) *plus* Amphotericin B (FUNGIZONE)

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality— the Priceless Ingredient*



Calms the Tense, Nervous Patient

in anxiety and depression

The outstanding effectiveness and safety with which Miltown calms tension and nervousness has been clinically authenticated by thousands of physicians during the past six years. This, undoubtedly, is one reason why meprobamate is still the most widely prescribed tranquilizer in the world.

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Miltown®
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS®—400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES
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Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
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The cigarette that made the Filter Famous!



It's true. Kent's enormous rise in popularity—with all the attendant magazine and newspaper stories—really put momentum to the trend toward filter cigarettes!

So, Kent is the cigarette that made the filter famous. And, no wonder. Kent's famous Micronite filter is made from a pure, all-vegetable material. A specially designed process at the P. Lorillard factory compresses this material into the filter shape and creates an intricate network of tiny channels which refine smoking flavor.

Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.

That's why you'll feel better about smoking with the taste of Kent.

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IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / expectorant
antihistamine / nasal decongestant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains: Hycodan®

Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming) Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law allows oral prescription.

Endo®

Literature on request

ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400



Emotional control regained . . . a family restored . . . thanks to a physician and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances, because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the reassuring fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Thorazine® brand of chlorpromazine
a fundamental drug in both
office and hospital practice
Smith Kline & French Laboratories

posed by professional models

'THORAZINE' PRESCRIBING INFORMATION

Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine® Reference Manual* and *Physicians' Desk Reference*, and from your SK&F representative or your pharmacist.

ADMINISTRATION AND DOSAGE

Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

ADULT DOSAGE

Mental and Emotional Disturbances (e.g., agitation, excitement, or anxiety)—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Alcoholism—Severely agitated patients: *Starting intramuscular dose* is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. **Agitated but manageable patients:** *Starting oral dose* is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

CHILDREN'S DOSAGE

For Behavior Disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery.

'Thorazine' Injection should not be mixed with other agents in the syringe. Because contact dermatitis has been reported with 'Thorazine', nurses or others giving frequent injections should avoid getting the solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight yellowish discoloration will not alter potency or efficacy. If markedly discolored, the solution should be discarded.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

CAUTIONS

Jaundice: The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals.

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease.

If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted.

Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vasoconstrictor is required, 'Levophed' and 'Neo-Synephrine'* are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Antiemetic Effect: The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

Neuromuscular (Extrapyramidal) Reactions: With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see *Physicians' Desk Reference*). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

SUPPLIED

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50, 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg. of chlorpromazine hydrochloride.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg. of chlorpromazine hydrochloride.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 6 mg. of sodium chloride.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 1 mg. of sodium chloride; 2% benzyl alcohol as preservative.)

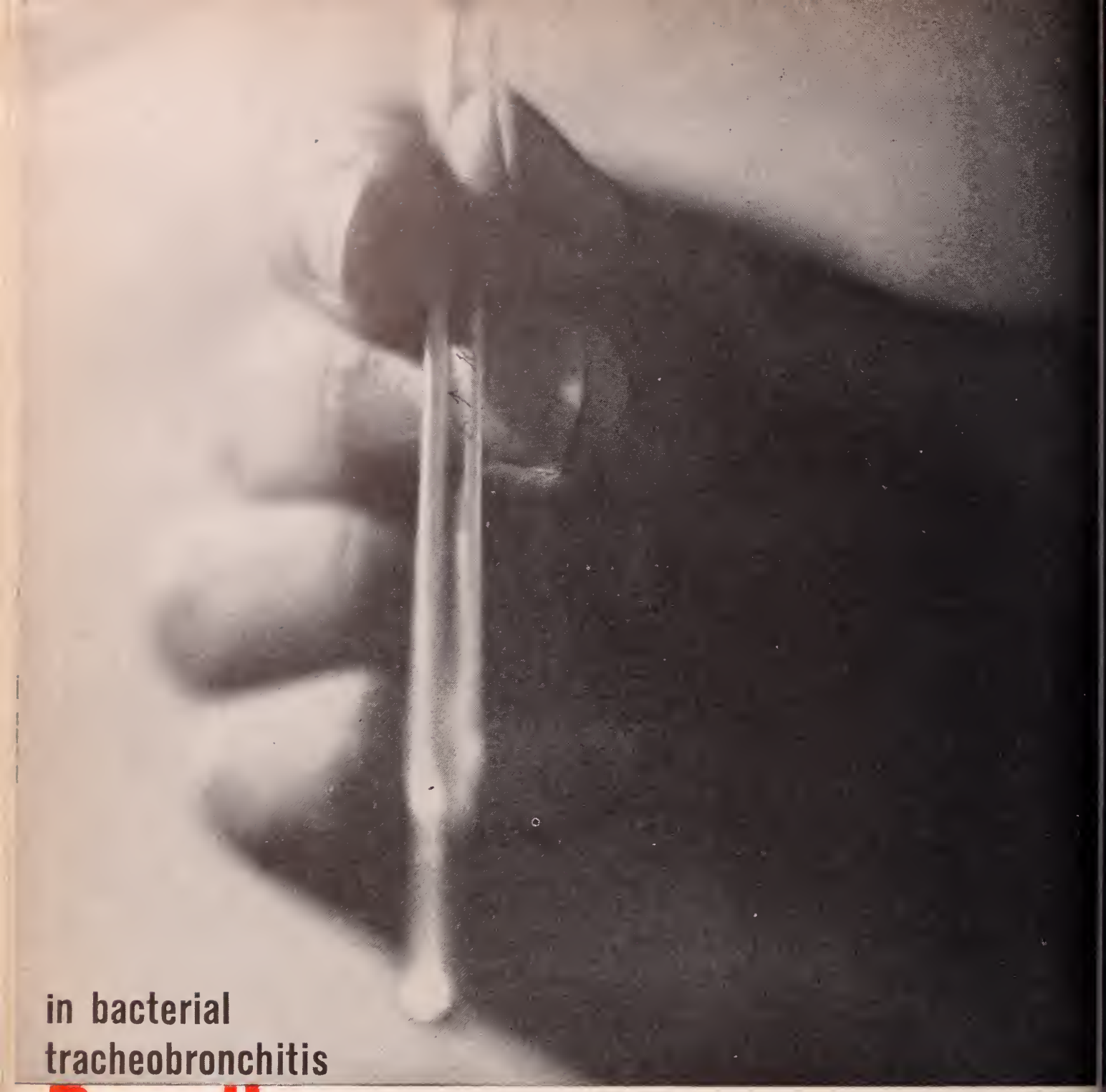
Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains 10 mg. of chlorpromazine hydrochloride.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains 25 mg. or 100 mg. of chlorpromazine; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

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*'Levophed' and 'Neo-Synephrine' are the trademarks (Reg. U.S. Pat. Off.) of Winthrop Laboratories for its brands of levarterenol and phenylephrine respectively.



in bacterial tracheobronchitis

Panalba* promptly

to gain precious therapeutic hours

In the presence of bacterial infection, taking a culture to determi bacterial identity and sensitivity is desirable—but not always practic in terms of the time and facilities available.

A rational clinical alternative is to launch therapy at once wi Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, inclu ing the ubiquitous staph. Use of Panalba *from the outset* (even pen ing laboratory results) can gain precious hours of effective antibio treatment.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

Usual Adult Dosage: 1 or 2 capsules 3 or 4 times a day.

Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.

Urticaria and maculopapular dermatitis, a few cases of penia and thrombocytopenia have been reported in pat treated with Albamycin. These side effects usually disa upon discontinuance of the drug.

Caution: Since the use of any antibiotic may result in growth of nonsusceptible organisms, constant observati the patient is essential. If new infections appear during apy, appropriate measures should be taken.

Total and differential blood counts should be made rou during prolonged administration of Albamycin. The poss of liver damage should be considered if a yellow pigme metabolic by-product of Albamycin, appears in the pl Panalba should be discontinued if allergic reactions tha not readily controlled by antihistaminic agents develop.

*Trademark, Reg. U.S. Pat. Off.
The Upjohn Company
Kalamazoo, Michigan

Upjoh

Panalba — your broad-spectrum antibiotic of first resort

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relieve U.R.I. distress rapidly

- relieve sneezing, runny nose
- ease aches and pains
- lift depressed feelings
- reduce fever, chills

For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, N. J.

Rx CORIFORTE™ capsules

Each CORIFORTE Capsule contains:

CHLOR-TRIMETON® (brand of chlorpheniramine maleate)	4 mg.
salicylamide	0.19 Gm.
phenacetin	0.13 Gm.
caffeine	30 mg.
methamphetamine hydrochloride	1.25 mg.
ascorbic acid	50 mg.

available on prescription only

when your tongue blade points to respiratory infection



Ilosone® works to speed recovery

Through the years, Ilosone has built an impressive record as an effective antibiotic in common bacterial respiratory infections. Numerous published clinical studies attest to excellent therapeutic response with Ilosone. Decisive recovery has become a matter of record.

Efficacy of propionyl erythromycin and its lauryl sulfate salt in 803 patients with common bacterial respiratory infections

92.3% 235 patients	Tonsillitis*
88.3% 317 patients	Acute Streptococcus Pharyngitis*
95.3% 85 patients	Bronchitis* (Bacterial Complications)
88.6% 166 patients	Pneumonia*

*References supplied on request.

The usual dosage for infants and for children under twenty-five pounds is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours.

For adults and for children over fifty pounds, the usual dosage is 250 mg. every six hours.

In more severe or deep-seated infections, these dosages may be doubled.

Ilosone is available in three convenient forms: Pulvules®—125 and 250 mg.†; Oral Suspension—125 mg.† per 5-cc. teaspoonful; and Drops—5 mg.† per drop, with dropper calibrated at 25 and 50 mg.

Product brochure available; write
Eli Lilly and Company, Indianapolis 6, Indiana

†Base equivalent
Ilosone® (erythromycin estolate, Lilly)
(propionyl erythromycin ester lauryl sulfate) 232534

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVIII, No. 7, January, 1962

Ten Years' Experience With Cholecystectomy

GEORGE M. STUBBS, M.D.
AND THAD MOSELEY, M.D.
JACKSONVILLE

Cholecystectomy is probably the most commonly performed upper abdominal operation. Often in the common procedures it is worth while to review one's results and to attempt to draw conclusions. This article presents a review of 236 consecutive cholecystectomies performed at the Riverside Hospital in Jacksonville during the 10 year period of July 1, 1950 to July 1, 1960. All of these operations were performed for gallbladder disease alone and do not include operations for pancreatitis, carcinoma of the pancreas, or other procedures on the biliary tract, although the gallbladder may have been indirectly involved.

Pathologic Classification

Surgeons are aware that obstruction of the cystic duct or the common duct initiates the episode of gallbladder colic. This is intermittent unless the obstruction becomes complete. After complete obstruction of the gallbladder it may become edematous and filled with its own mucus (hydrops), or if the blood supply is diminished, the bile acids and salts acting on the mucosa produce an acute gangrenous cholecystitis. Bacterial infection is not often a problem in acute cholecystitis, but does occur late in obstruction and produces a condition known as empyema. Free rupture of the gallbladder is uncommon because of the protective mechanism of the omentum and the viscera and did not occur in our series.

For the purpose of our discussion, we have classified our cases as shown in table 1.

From the Surgical Service of Riverside Hospital, Jacksonville.

Read before the Florida Medical Association, Eighty-Seventh Annual Meeting, Miami Beach, May 26, 1961.

Stones, of course, may also occur in the common duct, either from the gallbladder or having formed there primarily. Their presence leads to jaundice, colic, chills and fever. It must be borne in mind that jaundice may also occur with acute cholecystitis and in only 45 per cent of the cases is it due to common duct stones. In our series, there were seven of 11 cases with jaundice due to common duct stones, or 64 per cent. In the other instances, jaundice is usually due to an acute inflammatory reaction near the junction of the cystic and the common ducts with obstruction or concomitant cholangitis or possibly direct pressure due to a large stone in the cystic and the common ducts.

Sex and Age Incidence

There were 55 males and 181 females, a ratio of approximately 1:3. This is usual in a series of this type. The age incidence varied from 20 to 97 years with the largest group in the sixth decade and a comparable number in the fifth and the seventh (table 2).

Symptoms

The most common symptom was pain in the right upper quadrant of the abdomen or in the epigastric region with radiation through to the back, usually to the point of the right scapula. The pain lasted a few minutes to a few hours and was followed by soreness in the right upper quadrant for a day or two. This train of symptoms is known as gallbladder colic and was present in 157 of the 193 cases of chronic cholecystitis, or

Table 1. — Classification

Total cases — 236
Acute cholecystitis — 43 (19%)
Hydrops
Acute gangrenous cholecystitis
Empyema

Chronic cholecystitis — 193 (81%)
Colic with stones
Asymptomatic with stones
Contracted gallbladder

Table 2. — Incidence

Males 55
Females 181

Age	Number of Patients	Per Cent
0-20	0	
20-30	13	5
30-40	24	10
40-50	51	21
50-60	62	26
60-70	54	22
70-80	25	11
80-90	6	3
90+	1	

81 per cent. Severe, sustained pain in the right upper quadrant or epigastric region was more often a symptom of acute cholecystitis and was present in 40 of 43 cases, or 93 per cent.

The next most common site of the pain was the anterior portion of the chest or precordial region; it was present in this location in 16, or 9 per cent, of the chronic cases. It is well to remember that gallstones frequently occur with angina pectoris, and often the anginal symptoms are markedly improved after cholecystectomy. Pain in the left upper quadrant was also present in five of our cases, and this occurrence has been reported by other authors. The next most common symptom is dyspepsia; by this we mean flatulence, eructation, indigestion and other vague symptoms. Nausea was present in 51 and vomiting in 31 of the total number of cases. In most instances they occurred in the acute group. Fever was present in only 15 cases, again revealing the relative infrequence of bacterial infection. Other symptoms included loss in weight, diarrhea and constipation. Absolutely no symptoms were present in very few of our cases. Intolerance to fatty foods was seldom mentioned and had to be specifically asked about before it was stated as a complaint.

Roentgen Findings

The roentgen findings (table 3) when correlated with the surgical findings are interesting and again are probably based largely on blockage of the cystic duct. In roughly half of our cases, 48 per cent, there was good function, with stones visible on roentgen examination. Usually our surgical findings coincided roughly with the number of stones described by the radiologist. In 18 per cent of the cases, roentgenograms showed a nonfunctioning gallbladder but stones that were still visible. In 23 per cent, there was nonfunction without visible stones. Many things can happen to gallbladder dye during a test; so a report of a nonfunctioning gallbladder without stones should always call for a repeat examination. Often the gallbladder will be reported as normal on the second test. Our radiologists believe that in over 90 per cent of two consecutive studies showing nonfunctioning, stones will be present. This observation was borne out by findings that in 44 of 45 cases of two nonfunctioning studies, stones were present at surgery. Common duct stones can occasionally be seen on a routine cholecystogram and dilatation of the common duct may also be noted occasionally. In several cases of acute cholecystitis with a typical history and palpable gallbladder, gallbladder studies were not considered necessary.

Surgical Indications

The surgical indications for cholecystectomy depend on the division between acute and chronic cholecystitis. In chronic cholecystitis with cholelithiasis, we believe that anyone who is in reasonably good condition with symptoms of gallstone colic should have cholecystectomy. The morbidity of those in whom complications develop if they are not subjected to operation leads to this decision. As far as silent stones are concerned, nearly all surgeons agree that they should be removed for this same reason. Arbitrary age limits have been set, until recently, around 45 years of age. We think that 65 would be a more realistic figure.

In acute cholecystitis there has been much discussion about the time to operate. It was formerly thought that within the first 48 hours is optimal and that after that time several weeks should elapse. This thinking has changed, and at the present time it is our opinion and, we believe, the consensus among most surgeons that acute cholecystitis should be treated surgically at the time of diagnosis, allowing a reasonable time for the patient to be hydrated and brought into the best condition. Cholecystostomy is infrequently indicated in poor risk patients with acute cholecystitis. We used this procedure twice in this series, in a 97 year old woman with hydrops and

in an 83 year old woman with acute gangrenous cholecystitis. Both made a good recovery.

As far as exploration of the common duct is concerned, we have used more or less the classical indications. These are rather loosely interpreted by various groups and there is great variation in common duct exploration throughout the country. The Lahey Clinic some years ago reported 45 per cent common duct explorations, whereas Dr. Frank Glenn in New York reported 10 per cent. The average figure for the country seems to be somewhere around 20 per cent with positive findings consisting of common duct stones in 7 to 10 per cent of the total number of cases. In our series there were 36 common duct explorations, or 15.2 per cent, with a total incidence of stones in 13, or 5.5 per cent (table 4). In all of our cases in which the common duct was explored, T tube cholangiograms were obtained postoperatively, usually on the seventh or the eighth day. In two cases persistent stones were demonstrated, one being pocketed so that a probe passed by it and the other consisting of thickened, muddy material. These ducts were re-explored before the patients were discharged from the hospital, and both have remained well for several years. We have had no patients returned as yet with persistent or recurrent stones. It has been thought that exploration of the common duct adds to the mortality and morbidity of gallbladder surgery, but in our hands this result has not proved to be true.

Table 3. — Roentgen Findings

	Per Cent
Good function with stones	48
Nonfunction with stones	18
Nonfunction without stones (Two consecutive examinations)	23
Other	11

Table 4. — Indications for Common Duct Exploration

	Exploration	Positive
Jaundice or history of jaundice	11	7
Dilated common duct	12	2
Small stones with large cystic duct	5	1
Palpable stones	2	2
Thickened common duct	2	0
Other—stones on roentgen examination, pancreatitis, etc.	4	1
	36	13
Positive for stones		
Per cent of explorations	36	
Per cent of total cases	5.5	

Table 5. — Mortality

	Deaths	Per Cent
Total cases (236)	3	1.2
Chronic cholecystitis (193)	1	0.5
Acute cholecystitis (43)	2	4.4

Mortality

Our over-all mortality was three of 236 cases, or 1.2 per cent (table 5). In the 193 cases of chronic cholecystitis there was one death, an incidence of 0.5 per cent; in two of 43 cases of acute cholecystitis death occurred, an incidence of 4.4 per cent. The one death that occurred in the chronic cases was that of a woman aged 79 who had had a previous myocardial infarction and was having pain in the anterior portion of the chest with severe dyspepsia at the time of surgery. The operation was uneventful, and she was doing well until the fifth postoperative day, when, while sitting in a chair, she suddenly expired. Postmortem examination revealed an acute myocardial infarction.

The first death in the acute cases occurred in a woman aged 81 who had had repeated attacks of jaundice, chills and fever and had been advised to have surgery for several years. Finally, during an acute attack of jaundice and fever, the gallbladder was removed and stones were removed from the common duct. This patient did not do well following the operation and had a wound evisceration on the sixth postoperative day. Approximately 16 days after the surgical procedure, she expired from infection. The other death was in a 76 year old white woman, who was admitted to the hospital with acute pain in the right upper quadrant of the abdomen, a temperature of 101 F., muscle guarding and a questionable mass in the right upper quadrant. A gallbladder study revealed no function. The patient was hydrated and operated upon approximately 36 hours after admission to the hospital. She went into shock during the surgical procedure and although the operation was completed, she did not respond. Postmortem examination failed to show any definite cause of death. We believe that this patient probably was more ill than we had realized and should have had more intensive supportive therapy such as hydrocortisone and more vigorous antibiotic cover.

Morbidity

Numerous and various complications followed cholecystectomy in our series. The most striking feature is that the complications appeared so infrequently in operations for chronic cholecystitis with cholelithiasis and so relatively often in operations for acute cholecystitis (table 6 and 7).

Table 6. — Complications in Chronic Cases

CHRONIC CHOLECYSTITIS	NUMBER OF CASES
Wound disruption	2
Peptic esophagitis, severe	2
Abscess, right lower quadrant	2
Wound infection	1
Postoperative Ileus	1
Subphrenic bile collection	1
Pneumonia	1
Congestive failure	1
Gastric retention	1
Acute myocardial infarction	1
	13 (6.6%)

Table 7. — Complications in Acute Cases

ACUTE CHOLECYSTITIS	NUMBER OF CASES
Wound disruption	2
Missed common duct stone	2
Wound infection	1
Wound hematoma	1
Thrombophlebitis	1
Subhepatic abscess	1
Acute asthma	1
Congestive failure	1
Pneumonia	1
Unexplained surgical death	1
	12 (27.9%)

Complications occurred in 13 chronic cases, or 6.6 per cent, and in 12 acute cases, or 27.9 per cent. This relatively high complication rate in acute cholecystitis versus chronic cholecystitis seems ample reason for recommending cholecystectomy in persons with gallstones. These complications, of course, become much more serious in the older age group as evidenced by our mortality. It is noteworthy that in only one of our cholecystectomies was carcinoma of the gallbladder encountered. This was a tiny lesion and only found on microscopic section. The patient was dead within a year of metastases.

Results and Conclusions

We think that the over-all results with cholecystectomy have been good. In general, the reason for the good results is probably that all of the patients with chronic disease had gallstones and in most instances these gallstones were symptomatic. There is little or no reason for performing cholecystectomy for patients with chronic upper abdominal symptoms without the positive finding of stone, or for performing a cholecystectomy following one negative gallbladder study. It is likely that a large group of patients operated upon with these indications do not really have gallbladder disease but symptoms from other diseases. Probably the most important conclusion which we may draw from this review is that acute cholecystitis is a serious disease, particularly in the older age group, as evidenced by our morbidity and mortality. Persons with known gallstones who are in relatively good condition should be urged strongly to have cholecystectomy.

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Conservatism has been said to reflect a discriminating respect for the wisdom of one's ancestors. Few people are born respectors of this wisdom or show it in their childhood and youth, but experience tends to develop it. "In time a man comes to realize that prevailing customs would probably not have come into use had they not once served a purpose and would probably not have endured had they ceased to serve that or some other purpose."

Conservatism that is intellectually respectable boils down to the conviction that existing institutions, customs, rights, privileges and the like are a closely interrelated whole, reflecting the experience of many generations, and by and large, they are good rather than bad.

The thoughtful conservative, though he admires the sometimes awesome achievements of human reason as much as any liberal, is unwilling to submit himself entirely to the guidance of his own reason or the collective reasoning of his fellows. He has observed the withering effect of time on the fruits of reason — the disturbing frequency with which a scheme that appears reasonable one day seems less so the next and quite unreasonable a week or a month or a year later . . . he believes that the very faculty of discriminating should be used with discrimination.

From "The Reluctant Conservative" as quoted by Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, in an address presented at the State Medical Journal Conference, Chicago, Oct. 31, 1961.

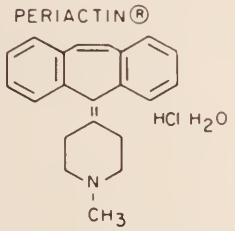
Treatment of Pruritus With a New Drug, Cyproheptadine

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Cyproheptadine is a new drug which has antihistaminic, antiserotonin, and tranquilizing properties. It was administered to pruritic patients for the purpose of evaluating its antipruritic property.

Nature of Cyproheptadine

Cyproheptadine is the hydrochloride monohydrate of 1-methyl-4-(5-dibenzo-[a,e,]-cycloheptatrienylidene)-piperidine. It has the following structure:



CYPROHEPTADINE HYDROCHLORIDE MONOHYDRATE

There is no sulfur or nitrogen in the ring system. The drug is not a phenothiazine, and there are no reports to indicate any evidence of parkinsonism, dystonia, agranulocytosis, or icterus.

Cyproheptadine was shown to be a potent antihistamine.[1] It antagonized the bronchoconstrictor, spasmogenic, and vasodepressor effect of histamine in various animals tested. The drug protected against passive and active anaphylaxis and, in addition, blocked histamine-induced gastric secretion in the dog, a property ordinarily lacking in antihistamine agents.

The compound demonstrated strong antiserotonin activity.[1-3] It antagonized a wide variety of serotonin effects such as the bronchoconstrictor effect in guinea pigs, the spasmogenic effect on isolated rat uterus, the vascular action in dogs, increased capillary permeability and the lethal effect in Hemophilus pertussis-treated mice.

The depressant action of cyproheptadine was evident in studies on cats and monkeys. In these animals the response was similar to chlorpromazine, but in some ways resembled that of scopolamine.

Toxicity[4] studies tend to show that the compound has an adequate margin of safety. No evidence has accumulated to indicate that the drug has renal, hepatic, or bone marrow toxicity. Carbohydrate metabolism is not altered. The chief side effect is sedation. Other symptoms, rarely reported, are nausea, vomiting, headache, and dryness of the mouth.

The dual antagonism of cyproheptadine to both serotonin and histamine makes it an interesting therapeutic drug. Antihistaminic substances generally do not possess antiserotonin activity. Both serotonin and histamine are mediators in the allergic state, but not necessarily the only ones.

Cyproheptadine compares favorably with other serotonin antagonists.[1] It is superior to BMS (1-benzyl-2-methyl-5-hydroxytryptamine) and BAS (1-benzyl-2-methyl-5-methoxytryptamine). It is about equal to lysergic acid diethylamide (LSD^{25}).

As an antihistaminic agent cyproheptadine may be compared favorably to chlorpheniramine and pyrilamine.

Procedure

Cyproheptadine was administered to 47 patients, ranging in age from eight to 73 years, who were treated for cutaneous pruritus arising from a variety of allergic and nonallergic dermatoses.

The drug was prescribed in 2 mg. doses four times a day to mildly pruritic patients and in 4 mg. doses four times daily to more severely pruritic patients. Once symptoms were controlled by the medication, the drug was gradually reduced and then discontinued.

No adjunctive therapy was ordered initially so as to determine the efficacy of cyproheptadine. Later, in some patients, grenz ray therapy was prescribed and topical medication such as bland emollient or petrolatum was applied to the skin.

Cyproheptadine was supplied as Periactin by Merck Sharp and Dohme Research Laboratories, West Point, Pa.

antihistamines were used when indicated. Mineral oil or hypoallergenic agents such as Lowila or Aveeno were used to cleanse the skin.

Excellent results were recorded if total or almost total relief was achieved, good if substantial relief was afforded, and poor if less than substantial relief was reported.

Results of Treatment With Cyproheptadine

Diagnosis	Number of Patients	Excellent	Good	Poor
Contact dermatitis	10	6	3	1
Atopic dermatitis	6	2	2	2
Urticaria	8	4	4	0
Scleroderma	2	0	2	0
Lichen planus	1	0	1	0
Psoriasis	2	0	1	1
Eczematous dermatitis	8	4	2	2
Dermatitis herpetiformis	1	0	0	1
Light dermatoses	5	3	2	0
Hodgkin's disease	1	0	1	0
Nummular eczema	3	1	1	1
Summary	47	20	19	8

Discussion

Cyproheptadine produced marked relief from itching when administered to 39 out of 47 patients. The antipruritic activity may, therefore, be considered quite satisfactory. The majority of the patients expressed their gratification with the relief afforded by the medication. These findings confirm the reports of other investigators.

The effect of cyproheptadine in two cases of scleroderma is worthy of comment. Both patients had involvement of the ankles and feet, with ulcerations. The drug softened the sclerodermatous skin and promoted healing of the ulcerations.

No serious side effects were noted. The most common side effect was drowsiness and this occurred infrequently. An occasional patient reported dryness of the mouth.

The antiserotonin, antihistaminic, and tranquilizing qualities of the drug are desirable properties for the treatment of allergic disorders. Reports indicate that cyproheptadine is a potent agent in the treatment of allergic disorders.[2,5,7] It has afforded relief to some patients not benefited by other antihistamines, possibly because of its antiserotonin activity.

Cyproheptadine[5,7,8] has been effective in relieving urticaria and allergic dermatoses as well as seasonal and perennial hay fever, being considered equivalent in activity to other antihistamines. It was disappointing in the treatment of asthma, a trait common to other antihistaminic agents. Migraine and premenstrual headaches respond well to cyproheptadine, suggesting a possible antiserotonin factor in their production.

Serotonin[1,4,5,9,10] has received increasing attention in recent years as a mediator in allergic reactions. It has been liberated from mast cells and platelets in the mouse, rats, and rabbit[11] during anaphylaxis. Serotonin is present in varying proportions in different species of animals in the lung, gastrointestinal tract, brain, platelets, and mast cells. The type of allergic response will probably vary with the site involved. Serotonin is often found in the same tissues as histamine, and its pharmacological activity is similar.

The role played by serotonin in human allergy[12] has not been fully clarified. The activity of serotonin in human skin[13] is equally uncertain. In the rat skin, however, it is an important metabolite.

Interestingly, hypersensitivity vasculitis experimentally induced in rabbits was suppressed and attenuated by cyproheptadine[2] but unaffected by tripelennamine and diphenhydramine which possess no antiserotonin action.

Summary

Cyproheptadine was administered to 47 patients with pruritic dermatoses. Thirty-nine were markedly relieved.

Sclerodermatous skin was softened and sclerodermatous ulcerations tended to heal under the influence of cyproheptadine.

No toxicity or serious side effects were noted.

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Experience With Intravenous Demerol With Lorfan for Analgesia and Anesthesia in Obstetrics

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When facilities for full time anesthesia coverage of obstetric cases are not available, the burden of providing sufficient anesthesia for delivery falls on the obstetrician. We have solved this problem by using analgesic agents in doses large enough to induce anesthesia during labor and delivery. "Heavy sedation" with intravenous Demerol has been a satisfactory procedure in our hands for many years, but the dangers of respiratory depression in the newborn child and circulatory depression in the mother due to narcotic drugs cannot be ignored. Intravenous administration of Demerol is considered more likely to cause untoward reactions than any other route.

Recent studies from England[1-4] report favorably on the use of a premixed solution of meperidine with a narcotic antagonist (levallorphan or nalorphine) to reduce these obstetric hazards. We have used a similar preparation (Demerol with Lorfan)* in 190 deliveries and are impressed with the results. In spite of an average intravenous dose of almost 200 mg. of Demerol during labor, a dose considered high by most obstetricians, no harmful effects to either mother or child have been observed in our patients.

Meperidine (Demerol) is probably the most commonly used and safest analgesic in obstetrics. Its intravenous and intramuscular use with scopolamine is well documented and will not be discussed here. Levallorphan (Lorfan) is a potent narcotic antagonist which counteracts respiratory depression caused by Demerol, morphine, methadone and alphaprodine. It does not affect respiratory depression due to barbiturates, anesthetics or other non-narcotic agents. Narcotic antagonists have been used in three ways in obstetric analgesia: given independently of the narcotic shortly before delivery; injected into the umbilical vein when breathing is delayed; or premixed with the narcotic and given during labor. The last method appears the safest and most convenient.

Estimates of the most suitable ratio of narcotic to antagonist have been variable, ranging from 50:1[2] to 100:1.[5, 6] Bullough[2] has favored a mixture of 100 mg. of meperidine and 2 mg. of levallorphan, a ratio of 50:1 for obstetrical analgesia, but is currently investigating the effects of an 80:1 ratio. Schiffrin, Balagot and Sadove[7] and Sadove, Schiffrin, Nickerson and Grove[5] have tested various ratios for the relief of chronic and postoperative pain. They found that a ratio of 60:1 produced excessive sedation, while ratios of 80:1 or 100:1 were sufficient to prevent depression and provide satisfactory analgesia. A ratio of 80:1 was particularly recommended to provide additional protection against depression. In studies of different drug combinations given during labor, Lloyd[6] concluded that 1 mg. of Lorfan will counteract the depressive action of Demerol without interfering with its other desirable properties. Roberts and her associates[8] observed a significant

*Demerol with Lorfan was supplied by the Medical Research Department, Winthrop Laboratories, New York, N. Y.

From the Good Samaritan and St. Mary's Hospitals, West Palm Beach.

reduction in anoxia of the newborn when a mixture of 150 mg. of Demerol and 1 mg. of Lorfan was given to women in labor. Lorfan did not affect analgesia and appeared to enhance the sedative action of Demerol.

Further evidence of the effectiveness of an 80:1 ratio of meperidine to levallorphan is provided by Cumming and Garner[4] and Lloyd and Brown.[3] Cumming and Garner[4] noted a slight reduction in analgesic potency, but saw no instances of immediate or delayed respiratory depression and no delayed apnea in 250 deliveries. The use of another antagonist, nalorphine, permitted very high doses of meperidine (1,000 to 1,600 mg.) to be administered during labor without danger to the fetus even when the narcotic was given close to full dilation.[1]

Our experience with a premixed solution of 100 mg. of Demerol and 1.25 mg. of Lorfan (a ratio of 80:1) is the subject of this report. This preparation was given intravenously to 190 patients in labor, to determine its effect on maternal analgesia and fetal respiration and to assess any harmful side effects.

Materials and Method

The patient group consisted of 190 women in labor, chosen consecutively, and they were unselected in terms of age, parity or any other factor. Fifty-eight were primigravidas (average age 23 years) and 132 were multiparas (average age 28 years). A preliminary dose of 4.5 grains of Nembutal was given orally to all patients and was the only barbiturate required in 127. In 51 patients, the initial dose was supplemented by 100 mg. or 150 mg. of intravenous Nembutal, while the rest received smaller doses of intravenous or intramuscular Nembutal. An intravenous injection containing 100 mg. of Demerol and 1.25 mg. of Lorfan was given during the first stage of labor, together with 1/100 or 1/150 grain of scopolamine, intramuscularly. The intravenous dose of Demerol with Lorfan was repeated approximately one hour later or as necessary. Most patients (104) were given two injections of Demerol with Lorfan, and no patient needed more than four injections (400 mg. of Demerol plus 5 mg. of Lorfan). The average dose per patient was 185 mg. of Demerol to 2.32 mg. of Lorfan. Primiparas required a larger dose on the average than did multiparas.

General anesthesia, consisting of nitrous oxide oxygen, was given to 20 primiparas and to 10 multiparas. A Trilene mask was used in one patient and saddle block anesthesia in another. No other medication was given during labor. All deliveries were vaginal and were preceded by infiltration of the skin of the perineum with 1 or 2 per cent Novocain (brand of procaine) for the episiotomy.

The effects of the narcotic-antagonist mixture on dilatation, degree and duration of analgesia and amnesia were noted for all patients. In some, respirations, blood pressure and pulse rates were measured after injection. Fetal heart rates were recorded before and after injection of the Demerol with Lorfan. During the second stage of labor we have given oxygen by mask to the mother as a prophylactic measure as advocated by Prystowsky in a recent personal conference with us. This procedure is strongly recommended as a means of ensuring rapid crying time in the newborn. All infants are aspirated with an electric suction apparatus by means of a small catheter inserted through the nostril into the stomach, thus emptying it of all swallowed amniotic fluid.

Results

Effect on the Mother:—Injections of Demerol with Lorfan did not affect dilatation or the duration of labor. In addition, the pressure, respiration or pulse rates, when recorded, remained within normal limits. Table 1 indicates the degree of pain relief afforded (excellent, good, moderate or poor), the onset of analgesia and its duration. The degree of amnesia is also noted. For the whole series, analgesia was excellent in 70.28 per cent, good in 14.85 per cent, moderate in 12.28 per cent and poor in 2.57 per cent of the injections given. Multiparas experienced more satisfactory pain relief on the average than did primiparas. In most patients (84.71 per cent), analgesia was immediate or within a few moments. The average duration of pain relief was one hour and 37 minutes. Complete amnesia occurred in 81.81 per cent of the series, there being little difference between primiparas and multiparas in this respect. Only 2.1 per cent reported no amnesia, and this condition was often associated with poor and short analgesia.

Effect on Delivery and the Fetus.—The fetal heart rate was measured before and after the injection of Demerol with Lorfan. A depression or elevation of 10 or more beats per minute was arbitrarily taken as significant. Table 2 shows that depression occurred in 20 instances and elevation in 10; no change in the fetal heart rate

Table 1.—Clinical Results in 190 Pregnant Women Given Demerol With Lorfan During Labor

	Primigravidas	Multigravidas	Total
Number of Patients	58	132	190
Average Age	23.05 years	28.01 years	26.53 years
Type of Delivery (Includes two sets of twins)			
Spontaneous	30	103	133
Spontaneous breech	0	1	1
Forceps	27	28	55
Assisted breech	1	2	3
Dosage			
Average per patient	220 mg. Demerol 2.75 mg. Lorfan	169 mg. Demerol 2.11 mg. Lorfan	185 mg. Demerol 2.32 mg. Lorfan
Median dose	2 injections	2 injections	2 injections
Degree of Analgesia			
Excellent	66.40 %	72.52 %	70.28 %
Good	16.40 %	13.96 %	14.85 %
Moderate	14.84 %	10.82 %	12.28 %
Poor	2.34 %	2.70 %	2.57 %
Onset of Analgesia			
Immediate	84.51 %	84.85 %	84.71 %
Slow	13.79 %	12.12 %	12.63 %
Very slow	1.70 %	3.03 %	2.63 %
Duration of Analgesia			
Average per patient	1.7 hours	1.6 hours	1.62 hours
Degree of Amnesia			
Complete	81.73 %	81.86 %	81.81 %
Partial	17.39 %	15.34 %	16.06 %
None	0.87 %	2.79 %	2.10 %

was noted in 161. The changes ranged from an elevation of 20 to 12 beats per minute to a depression of 22 to 30 beats per minute in the multiparas and primiparas respectively. The greatest variation in primiparas (from a depression of 28 beats per minute to an elevation of 12) occurred in the same patient on two consecutive injections. In this patient, a general anesthetic was given and delivery was by forceps. The baby breathed and cried immediately, without assistance. In another primipara a depression of 30 beats per minute occurred during general anesthesia, but did not adversely affect the infant. There did not appear to be any consistent relationship between the depression or elevation of the fetal heart rate and the condition of the infant at birth, but in five of the 10 primiparas, depression was associated with nitrous oxide-oxygen anesthesia.

The average time between the last injection of Demerol with Lorfan and delivery was 61 minutes, with a range of two minutes to over nine hours. The time interval was longer for primiparas (approximately one and a half hours) than multiparas (46 minutes). Neither a very long nor a very short time interval was correlated with the condition of the infant at birth or the need for resuscitation.

Babies were classified into four groups according to their condition at birth. Group I breathed and cried spontaneously within 60 seconds of birth. Group II breathed and cried spontaneously one to two minutes after birth. Group III consisted of babies whose breathing and crying times were one to two minutes aided by nasal oxygen. In Group IV were babies who breathed and cried two to four minutes after birth and who were all helped by oxygen and/or resuscitation. Resuscitation was required in only 11 infants and consisted of giving oxygen by mask. Further measures such as use of an intratracheal tube or laryngoscope were not necessary. All the babies requiring this treatment were graded over 4 points on an Apgar scale which accounts for the ease with which they were handled. Thirteen infants were cyanotic.

Table 2.—Variation in Fetal Heart Rate After Injection of Demerol with Lorfan

Fetal Heart Rate	Primigravidas	Multigravidas	Total
No change	46	115	161
Depression	10	10	20
Elevation	3	7	10
Totals	59*	132	191*

*Included in the total is one patient for whom two consecutive deliveries produced a significant reversal in fetal heart rate.

Table 3.—Breathing and Crying Times in Newborn Infants

Classification*	Breathing Time	Crying Time	
Group I	164	163	Spontaneous
Group II	7	8	
Group III	10	8	Induced by Oxygen
Group IV	9	11	

*See text for description of Groups I to IV.

Table 4.—Side Effects in One Hundred Ninety Mothers

Reaction	Number of Patients	Percentage of Total
Drowsiness	190	100.00 %
Euphoria	87	54.79 %
Vomiting	6	3.15 %
Nausea	4	2.10 %
Vertigo	1	0.52 %

Table 3 indicates the condition of the babies and the number in each group. There were no infant deaths.

SIDE EFFECTS IN THE MOTHER.—Some degree of drowsiness was experienced by all patients and did not interfere with labor (table 4). Euphoria occurred in 87 patients. Undesirable reactions were few, consisting of nausea in four, vomiting in six and vertigo in only one patient.

Discussion

Excellent or good relief was experienced by approximately 85 per cent of the patients. This figure compares very favorably with the degree of analgesia afforded by intravenous or intramuscular administration of Demerol alone as reported by others[9] or as seen in our practice. Analgesia was not diminished by the addition of Lorfan, and it is our impression that relief of pain was better.

Amnesia was more pronounced after Demerol with Lorfan. The incidence of absolute amnesia in 81.81 per cent of our patients is higher than that observed by Schumann[10] using Demerol alone. He found complete amnesia in 70.5 per cent of women and none in 12.6 per cent. In a study comparing different narcotic-antagonist mixtures, Bullough[2] noted that amnesia appears intensified by the addition of nalorphine or levallorphan to meperidine.

Evidence about the possible harm to the fetus from injections of Demerol given immediately prior to delivery is conflicting. A recent paper[11] finds that medication injected two to three hours before delivery affects the newborn baby more than that given during the last hour of labor. Gottschalk[12] found that intravenous Demerol injected 10 minutes before delivery is not harmful. On the other hand, Patterson[13] thought that Demerol is more likely to depress fetal respiration if injected very close to the time of delivery. Our results do not resolve this issue, but offer evidence that intravenous doses of 100 to 400 mg. of Demerol are safe during all stages of labor if the narcotic is premixed with appropriate amounts of Lorfan. A careful study was made of patients with the longest and shortest times between the last intravenous injection and delivery. No correlation between time interval and respiratory status of the infant was apparent.

Most infants breathed and cried spontaneously within 60 seconds of birth, and only 20 required assistance from oxygen. Delayed breathing and crying time and the need for oxygen were not associated with any of the following factors: total amount of Demerol administered during labor; time between injection of Demerol with Lorfan and delivery; depression of fetal heart rate after delivery, or the use of nitrous oxide-oxygen anesthesia for delivery.

Conclusions

In the absence of anesthetic facilities, adequate obstetric anesthesia for labor and delivery can be safely provided by intravenous Demerol combined with Lorfan.

A ratio of 80:1 (100 mg. of Demerol plus 1.25 mg. of Lorfan) prevented in this study circulatory depression in the mother and cardiopulmonary distress in the fetus.

The analgesic and amnesic properties of Demerol and scopolamine are not reduced by the simultaneous administration of Lorfan.

The incidence of untoward reactions is not increased by Demerol with Lorfan while sedation appears to be enhanced.

In view of the excellent status of almost all of the 192 infants delivered in an unselected

series of 190 mothers and the lack of complications related to respiratory depression, we can recommend, when used with the usual caution, as for any potent intravenous medication, the administration of intravenous Demerol with Lorfan for analgesia during labor and anesthesia for delivery.

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Anterior Cervical Spine Fusion

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There is constant need for revising and adding to our armamentarium in the approach to medical problems. In solving problems of instability, interbody fusions have been accomplished frequently, especially in the cervical spine and in the lumbar spine.

There has been reluctance on the part of surgeons to accept the challenge of the anterior approach to the cervical spine for interbody fusion. The reason is obvious. The posterior cervical spine fusion has served the purpose of stabilization satisfactorily in most instances. This procedure will maintain its popularity as a safe and standard approach to gain stability in the cervical spine. It is not the purpose of this presentation to suggest supplanting the posterior cervical spine fusion; instead, certain factors relative to the use of anterior cervical fusion are discussed and two cases presented.

Report of Cases

Case 1.—A white gasoline attendant, 20 years old, was admitted to the hospital on July 22, 1959 with a neck injury. The patient, involved in an automobile accident, had been thrown against the dashboard and then out of the car. No loss of consciousness and no associated neurological findings were noted. Roentgenograms showed a fracture dislocation involving the fifth and sixth cervical vertebrae. Laminagrams showed multiple fractures of the laminae and pedicle of the fifth cervical vertebra.

During the early weeks of his care, attention was focused on a bladder dysfunction which proved to be only a transient hypotonia. By the seventh week, when the Crutchfield tongs, which had been used to secure and maintain reduction, had been removed, it became evident that further stability to restore a normal relationship between the fifth and sixth cervical vertebrae was indicated. A posterior fusion was rejected since it meant a long period of immobilization. The present reduction seemed inadequate since it appeared to be crowding the nerve root exit. The anterior fusion could be accomplished without any follow-up immobilization, but a more important consideration was that it would restore some height and space at the level of the fifth and sixth cervical vertebrae and thus assure more room as the nerve passed through the foramen on either side.

On September 15, through a right anterior cervical approach, dowel grafts taken from the patient's left ilium were inserted. Because of the extreme instability of the fifth cervical vertebra which was not sufficiently controlled with the bone graft between it and the sixth cervical vertebra, it was thought necessary to insert a second graft between the fourth and fifth cervical vertebrae.

The significant operative details were as follows: A transverse incision was made on the right side of the neck through a skin crease just proximal to the cricoid cartilage extending approximately 6 cm. The platysma muscle was incised perpendicular to its fibers. The superficial fascia of the neck was dissected bluntly, and the carotid sheath was dissected and retracted laterally. The thyroid, larynx and esophagus were retracted medially. The prevertebral fascia was then immediately available and was incised in the direction of its fibers down to and including the central fibers of the anterior longitudinal ligament. A

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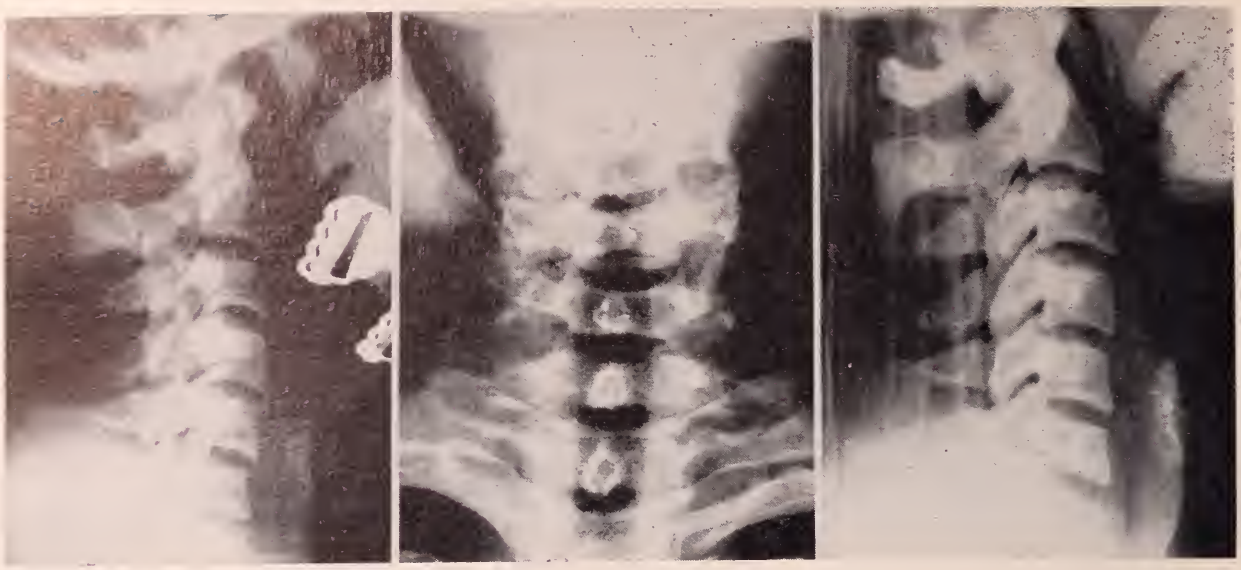


Fig. 1.—a. A 20 year old man with a fracture dislocation involving the fifth and sixth cervical vertebrae with fractures involving the laminae and pedicle of the fifth cervical vertebra. A lateral view in traction. There were no major associated neurological findings. b. On the anteroposterior view there was a loss of height of the fifth cervical vertebra and diminution of the foramen on the right suggesting a possible source of future nerve root irritation. c. Twelve pounds of Crutchfield tong traction has maintained a normal cervical alignment one week after injury.

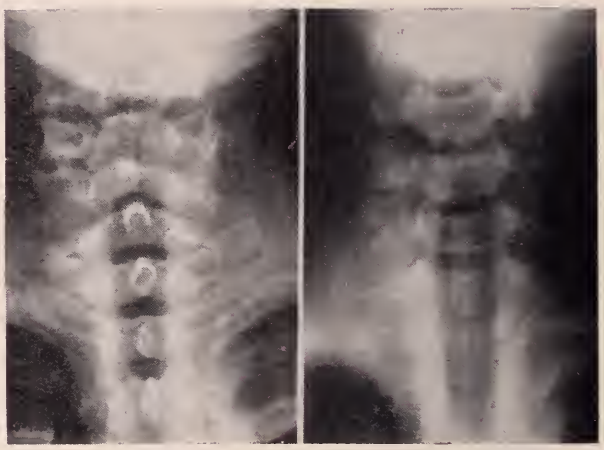


Fig. 2.—a. Another anteroposterior view showing disruption of the foramen on the right of the fifth cervical vertebra. b. One of a laminagram series showing narrowing of the foramen on the right involving the fifth and sixth cervical vertebrae.

Fig. 3.—a. An anteroposterior view after operation showing the position of the two dowel grafts. The graft at the fourth and fifth interspace is slightly eccentric to the left. The graft at the fifth and sixth interspace is directly in the center. Both grafts are noted as round shadows. b. A lateral view showing the dowel interbody grafts in position. c. A lateral view in hyperextension after 10 weeks showing secure fixation. (below)



needle was placed in the interspace between the fifth and sixth cervical vertebrae, and a confirmation of this space was obtained with a roentgen examination at this time. Identification was also easily made because of the instability of the fifth cervical vertebra.

The Cloward instruments were used and found to be of great value since the retractors maintained appropriate working space for the drill and rongeur. The drill was sharp and did not need a great deal of pressure to cut the smooth, round hole which was centered on the interspace. As the cutting proceeded, one half of the circle was cut from the inferior side of the fifth cervical vertebra and the other half of the circle was cut from the superior surface of the sixth cervical vertebra. A certain amount of the intervertebral disk was retained in the interspace, and it was necessary to withdraw the drill frequently and remove the pieces of fibrocartilage and disk material with a rongeur or curet. A frequent cleaning of the interspace and survey of the depth as the drilling proceeded were important in order to recognize the moment of breaking through the cortex of the posterior aspect of the body. Drilling was discontinued at this time to preserve the posterior longitudinal ligament.

Although it has been thought that stopping just short of the posterior cortex was probably the safest maneuver, it would seem that a more secure bone graft would be obtained if the dowel graft were to be fitted with exact



Fig. 4.—a. A lateral view six months after operation for interbody fusion with flexion showing a solid fusion. The patient is asymptomatic. b. A lateral hyperextension view six months after operation. No postoperative brace or fixation was used.

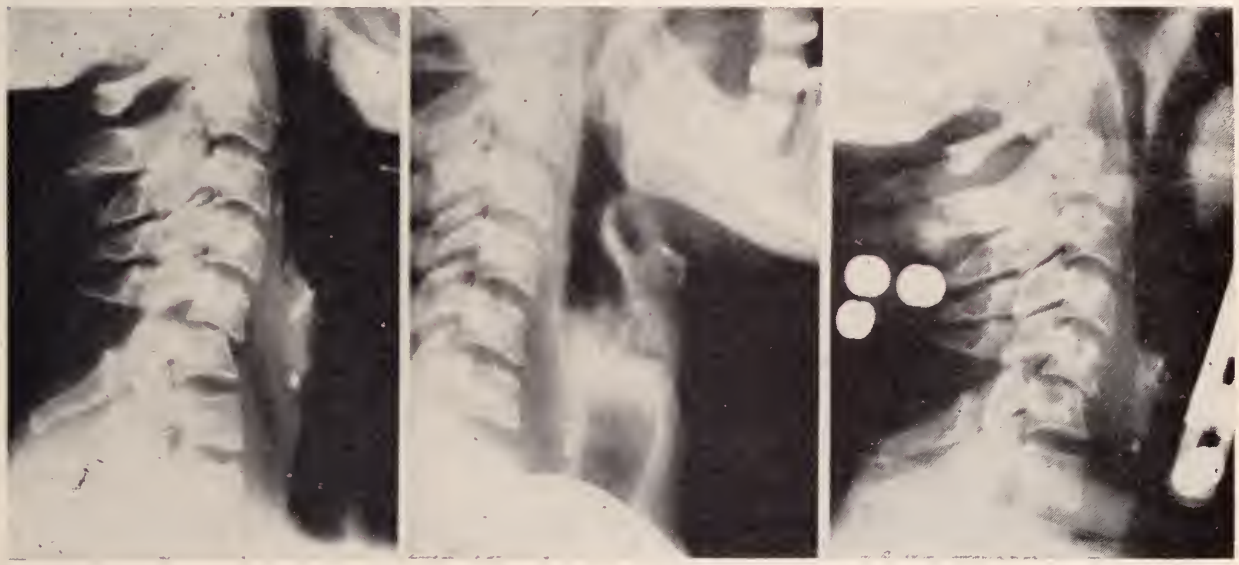


Fig. 5.—a. A 50 year old housewife with a dislocation of the fifth cervical vertebra on the sixth cervical vertebra with no associated neurological findings. b. Reduction of the dislocation was obtained with skeletal traction (Blackburn tongs). c. There was a loss of reduction when the patient was allowed up in a cervical collar six weeks after injury.

centering and complete insertion were accomplished. A disadvantage of leaving a thin posterior cortical wall was the possibility of breaking loose the posterior part of the cortex of the vertebra as the dowel was fitted into place. This would be an unrecognized incident at the time of insertion of the graft. The small fragments of cortical bone that were left were removed with the rongeur and curet. The posterior longitudinal ligament was not injured.

There had been some question as to whether or not the instability of the fifth cervical vertebra would allow for the drilling that would be necessary. This did not appear to be a problem although there was visible rocking of the fifth vertebra as the drill proceeded which was not noticed on either the sixth or the fourth cervical vertebra. There was a question as to whether or not making a second circular cut of the fifth cervical vertebra

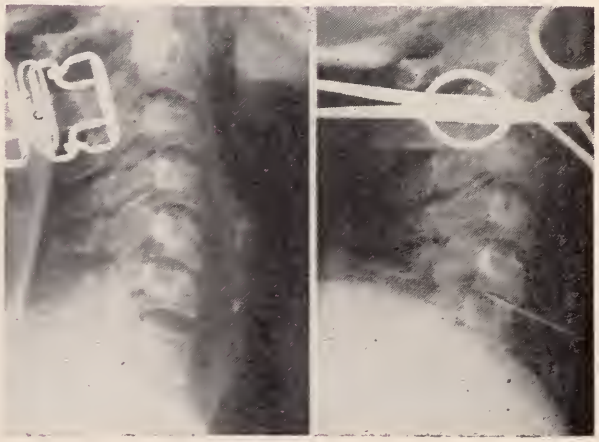


Fig. 6.—a. The dislocation was again reduced with traction, and an interbody fusion was planned through an anterior approach. b. A lateral view taken at operation confirmed the involved interspace.



Fig. 7.—a. A lateral view in flexion two weeks postoperatively. b. A lateral view in hyperextension two weeks postoperatively. c. An anteroposterior view to show the position of the dowel graft two weeks postoperatively.

from above would leave insufficient contact of the body itself and whether or not the body would split. This cut, therefore, was made slightly off center with more of the circle being cut out of the fourth cervical vertebra.

It was evident immediately that the stability of the cervical spine was considerably improved when the dowel graft was inserted at the area of the fifth and sixth cervical vertebrae. Stability was even more adequately secured after the second dowel graft at the area of the fourth and fifth cervical vertebrae was inserted. It was also evident that the dowel grafts were inserted with a close, tight fit, with the surfaces of the bleeding red bone of the dowel graft directly opposed to the bleeding red bone of the vertebra. It was thought that two cancellous surfaces of bone had been well opposed and would, therefore, secure a rapid binding union.

The neck was not held in extreme hyperextension for fear the patient would not get sufficient flexion afterward. Instead, it was held in moderate hyperextension and at the time of completely inserting the grafts was brought back into a normal position which then seemed further to insure fast and secure contact of the two grafts as well as to lock them in place. It was noted that hyperextension of the neck did not loosen the position of the grafts under direct vision. The tissues of the neck fell back into place as retraction was withdrawn, and the carotid fascia was sutured back into position closing the area of exposure. The wound was closed by using small fine sutures in the subcutaneous tissue and skin. A small dressing and soft collar were applied.

Postoperatively the patient did extremely well and the next day was sitting up without neck support other than a small soft bandage. A partial Horner's syndrome was present on the right side postoperatively; however, the lid lag cleared by the fifth postoperative day. It was difficult to determine the extent of this syndrome since a permanent pupillary change had been present since birth.

It became evident fairly early in the postoperative period that the prolonged skeletal traction prior to the operation had resulted in a moderate "limber neck" which appeared to need some support. A soft wrap-around collar for approximately 10 days was sufficient to give the patient a more secure feeling. By that time he had gained sufficient muscular control to obviate its use. He was dismissed from the hospital 10 days following the operation with a completely healed wound, no bandage and no neck support; he stated that the neck felt normal. Now he reports that the neck feels just as it did before he was injured. There is certainly a full range of motion, and



Fig. 8.—a. In hyperextension six months postoperatively the fusion is shown to be solid. There is extravasated calcification of hematoma under the anterior longitudinal ligament. b. In flexion six months postoperatively there is secure fixation. The patient is asymptomatic. No postoperative brace or fixation was used.

no evidence of any limitation is present. The roentgen examination at six months showed sealing of the bone grafts. They now appear to be a part of the normal bony structure of the vertebra.

One might certainly question the necessity for the use of an anterior fusion in this cervical injury case. It must be recognized, however, that one needs to consider the future arthritic changes following a fracture which may encroach upon the foramen giving rise to the late associated symtoms occurring in neck injuries which can be relieved only by a foraminotomy.

Case 2.—A white housewife, 50 years of age, slipped and fell, striking the occiput against a sharp object and forcing the chin against the chest one week prior to admission to the hospital on Sept. 2, 1959. Roentgen examination showed that there was an anterior dislocation of the fifth cervical vertebra on the sixth vertebra with a displacement approximately one third of the width of the cervical body and with no gross fractures in evidence. It was remarkable that she experienced no neurological

deficit other than a minimal paresis of the ulnar aspect of the right hand and arm.

The patient was placed in 15 pounds of skeletal traction. The dislocation was readily reduced. It was maintained with 5 pounds of traction until September 29, three and a half weeks after admission, at which time a brace was applied and the patient was allowed to get up. She had refused operative intervention for cervical spine fusion of the standard posterior type and requested brace treatment. It was noted on immediate roentgen re-examination that there was subluxation of the fifth cervical vertebra upon the sixth cervical vertebra, and the patient was immediately placed back in bed with a head halter traction. At this time head halter traction was sufficient to give the reduction that had been secured previously.

In view of the fact that the patient had a history that was suspicious of chronic alcoholism with the possibility that she would not give sufficient protection to a posterior fusion, anterior cervical spine fusion appeared to be highly advantageous since no immoblization would then be necessary.

Ten days after the reduction was once again secured, an anterior cervical fusion was performed with the dowel interbody graft taken from the left ilium and inserted between the fifth and sixth cervical vertebrae. A left side approach was utilized. A needle was placed in the interspace, and roentgenograms were made to confirm the localization of the interspace. Again definite instability showed at this interspace and made identification easy. The interbody dowel graft was inserted in the interspace between the fifth and sixth cervical vertebrae with the neck in moderate hyperextension. When the neck was placed in normal position, the graft appeared to be solid and did not move. The dowel graft should be kept smooth and not trimmed too radically since this aids in securing a tight fit. If a dowel is loose, it is best to discard it and use a different dowel graft.

The immediate postoperative care was without incident, and there were no complications. The patient was allowed to have sitting activity determined by her tolerance.

Following wound healing, the soft collar was gradually discarded, and within 13 days of the operative procedure the patient was dismissed from the hospital with no bandage, no neck support and no complaints. The follow-up roentgenograms showed excellent fusion with solid union occurring within a six month period and suggested early fusion two months following the operation.

Comment

There is a limited area which lends itself to anterior approach with the ease with which the operation was performed in these two cases. This area is from the third cervical vertebra to and including the seventh cervical vertebra. The dowel interbody graft may be best used to advantage when it is inserted in the central portion of the normal lordotic curve of the cervical spine which, of course, is in the area of the fourth, fifth and sixth cervical vertebrae. Some of the mechanical difficulty that has been experienced with the interbody fusion in the lumbar spine will probably not be encountered in the cervical spine because of the type of curvature and the lesser weight forced against the dowel graft. There is no doubt but that the method demands a skilled and experienced hand. There were no complications in these two cases that were of significance. In a previous report by Smith and Robinson,[7] the following complications were noted: Horner's syndrome, transient paralysis of the vocal cords, tracheitis, perforation of the vertebral artery and rupture of the esophagus.

The technique of the anterior approach for a cervical spine fusion appears to have been extremely useful in the cases presented. The procedure has been previously demonstrated to be useful following cervical disk removal, in cases of disk degeneration associated with osteoarthritic changes giving nerve root irritation and compression and in cases of instability with a forward extrusion of a portion of the anterior part of a cervical body. It may well be useful in maintaining the height of the anterior portion of compression fractures of the cervical spine when there has been a loss through comminution of the body. It should be useful following extensive posterior laminectomy when posterior fusion is notoriously difficult and uncertain.

This procedure should be used only after considerable judicious thought on the part of the specialist and should not be casually approached by the average surgeon.

Conclusion

Two cases are reported in which the anterior approach for cervical spine fusion was used successfully with fracture and fracture dislocation problems at the level of the fifth and sixth cervical vertebrae. Advantages of the procedure are demonstrated.

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President's Page

Presidents and Secretaries Conference

Dissemination of facts concerning current events in the Florida Medical Association has always been a problem and to some extent still is. Various forms of communication such as Briefs, The Journal of the Florida Medical Association, one annual meeting and annual district meetings have been tried.

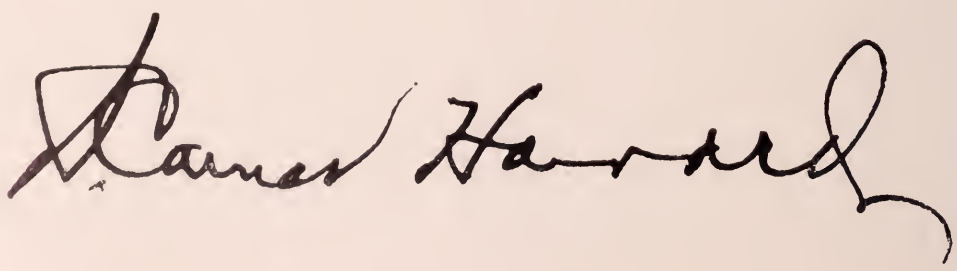
In 1958 it became apparent, because of poor attendance and subsequent lack of interest, that the district meetings were not in any way worth the effort of the few and the money that it cost to put them on. Anybody who made the "circuit" can testify to the fact that it was four days of grueling work and you were left with the feeling that very little had been accomplished. Of course, it was nice from a social standpoint, but very little knowledge was given out and less obtained.

Consequently, the idea of an annual County Medical Society Presidents and Secretaries Conference, to be held in the middle of the year, was conceived. The first conference was held in 1959, at which time there were 34 physicians present with 21 county medical societies represented; they in turn represented 79 per cent of the total Florida Medical Association membership. The total attendance at this meeting was 57. Last year there were 35 physicians present with 22 county medical societies represented; they in turn represented 88 per cent of the total Florida Medical Association membership. The total attendance was 76.

Your County Presidents, Presidents-Elect and Secretaries have already received a memorandum from me with the program for the meeting of January 13 and 14, 1962. It is my earnest desire that every component society be represented at this meeting. This goal can be reached if each member will make it his duty to insist that the Presidents and Secretaries attend and help them to do so. As you can see from the program, an effort is being made to cover every phase of our current activities. If your society is represented, nobody can say later that the members knew nothing about a certain subject which was brought up. It will also help to expedite your proceedings at the next annual meeting. If it is absolutely impossible for either your President or your Secretary, or both, to attend, send someone in their place to represent you. HAVE REPRESENTATION.

The annual Presidents and Secretaries Conference not only brings the smallest society up to date on current events in the organization but it also gives this society an opportunity to air its own problems. As I have stressed before, the closer knit organization we have and the better we understand problems at the "grass-root" level the stronger our organization will be.

Let us all get together and have 100 per cent representation of the county societies.



EDITORIALS



Our Relations With Osteopathy

Can doctors of medicine accept any second best system of practice or recognize as professional equals practitioners of any healing art which is not founded upon accepted truths and scientific facts? These questions were answered emphatically in the negative by the Board of Governors at its meeting on September 30 when it made this pronouncement: "The public looks to doctors of medicine, members of this Association, not only for medical care but also for accurate guidance on questions relating to health and medicine. Should this association or its individual members do anything to suggest its approval of cultism or cultists, or of the practice of unscientific medicine, not only would it be a disservice to the public, but it would also be a misuse of public trust." At the same time, it endorsed the policy adopted by the House of Delegates of the American Medical Association in June 1961: "There can never be an ethical relationship between a doctor of medicine and a cultist; that is one who does not practice a system of healing founded on a scientific basis."

The Board of Governors declared that the practice of cultism is not a matter of degree and any osteopath who adheres to the original tenet of osteopathy is a cultist. It recognized that many, licensed as osteopaths, have veered away from its basic concept and are practicing a dilute type of medicine. It recommended that studies be made whereby those individuals, licensed as osteopaths, who desire to be recognized as practitioners of scientific medicine, can pursue courses of study and training through the facilities of medical schools and postgraduate medical education to obtain a degree of Doctor of Medicine, entitling them to be recognized by other doctors of medicine as professional colleagues. At the present time, there appears to be no demand in the state for these facilities, and the Board thought that until such a time does exist the door should be kept open and such proposals welcomed without the Association initiating any steps in this direction.

The House of Delegates of the American Medical Association recognized that problems pertaining to osteopathy are peculiar to the several states and recommended a declaration of principles at state levels. In like manner, the Board of Governors realizes different problems are present in the same state at county levels, depending upon the physician concentration, the availability of medical and hospital care, the quality of and economics involved in this care and the varying management and staff organizations of hospitals. For this reason, it was thought that no broad policy, covering all situations in the state, could be made at this time and it was recommended that component county societies of the Association establish policies regarding relationship of doctors of medicine with osteopaths within their own area. Complaints or problems which cannot be solved at local levels should be submitted through appropriate committees to the Association for consideration and action.

It was further stated by the Board that since the right to practice a healing art in a hospital is generally controlled and granted by boards composed of lay members, it shall not be considered an unethical act per se for a member of this Association to practice in a hospital required by law or its rules and regulations to admit cultists to practice, provided he does not enter into any professional relationship with them.

This, then, is a summary of principles and statement in regard to osteopathy adopted by the Board of Governors at its last meeting. Since the medical profession is dedicated to the best quality of medical care for all people, the Board had no option but to declare that until the present over-all situation throughout the state changes, our attitude withholding professional recognition

of osteopaths as a group must be maintained. At the same time, this member of the Board had a definite impression that the wish to extend a helping hand to those who sincerely desire to spend the time and effort to qualify for the degree of Doctor of Medicine was genuine and void of any sense of arrogance. The degree of Doctor of Medicine does not confer upon the recipient the right to stagnate. Medicine must be a continuing program of education for its members who are doctors in fact as well as name. If many of them do not consider the sacrifice too great to give up one or more years of practice for additional hospital or postgraduate training to improve their professional stature, is it not reasonable to expect osteopaths to do as much if they desire professional equality?

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Orlando

Management of Acute Cholecystitis

Despite all the written and spoken words on the management of cholecystitis which have inundated the medical profession since the early days of cholecystostomy, much confusion persists in the actual day-to-day management of a case of acute cholecystitis. On the one hand, there is a large group who advocate "cooling off" the acute attack with intravenous fluids, antibiotics and nasogastric suction followed by an elective cholecystectomy in six to eight weeks after subsidence of the attack. At the opposite pole are those who advocate immediate surgery if the patient can be operated upon in the first 72 to 96 hours after the onset of the attack. While both groups present potent arguments to substantiate their viewpoints, it is apparent that there are inherent weaknesses in each.

Even the most vociferous advocate of the expectant school admits that there are certain cases —albeit small in over-all percentages — which will fail to respond to a nonoperative regimen, and when failure occurs, emergency surgery must be performed in a seriously ill, rapidly deteriorating, poor risk patient.

On the other hand, since many patients suffering an acute attack of cholecystitis will be treated at home for the first 36 to 48 hours, this delay places the advocates of early surgery in the position of having only 24 to 48 hours in which to confirm the diagnosis, establish homeostatic balance and deliver to the operating amphitheatre a patient in optimal condition for major biliary tract surgery.

There are ramifications of these inherent weaknesses of the two approaches cited. The nonoperative method tends to leave the surgeon with little experience in the technical aspects of the surgery of acute cholecystitis, yet expects him to cope successfully with the most difficult cases of all, the failures of this particular regimen. The early operation school opens the door to the possibilities of undue haste, errors in diagnosis and inadequate preoperative preparation.

Throughout our surgical career and in our training of surgical residents, we have not adhered to either approach mentioned. Based upon long term clinical experience, we advocate definitive surgical management of an attack of acute cholecystitis when the diagnosis has been established definitely and when the patient has reached, through deliberate and orderly preoperative preparation, optimal homeostatic balance at anytime up to and including the tenth day following the onset of the attack.

Recently, with our associates we reported elsewhere a detailed analysis of our statistics utilizing this approach in a seven year period on the staff side of the Jackson Memorial Hospital consisting of 287 operative procedures. At the same time, these statistics were compared with a series of 678 elective gallbladder operations performed during the same period on the private and staff services which included not only those treated initially by a medical regimen and operated upon six to eight weeks later but also elective cholecystectomy for cholelithiasis in which there had been no attack of acute cholecystitis. A third series was analyzed also — those patients with acute cholecystitis in that same period who either failed to respond to the nonoperative approach

or their surgery was postponed for other reasons and necessitated emergency surgery 11 or more days after onset of the attack (107 cases).

There was a strikingly similar morbidity and mortality in the first two groups (1.74 per cent mortality for surgery in the first 10 days; 1.62 per cent mortality for the elective surgical group) even though in 12 per cent of the cases in each group the patients were over 70 years of age and in no way, really, can one compare a planned elective hospital admission and gallbladder operation to an attack of acute cholecystitis treated by cholecystectomy. It is of very considerable significance that in those cases in which operation was delayed beyond the tenth day with medical management or for other reasons only to require emergency procedures subsequently, the mortality rose to a prohibitive 10.28 per cent.

There have been added dividends to this approach. In the elective group, there had been 320 hospital days utilized in previous admissions for gallbladder disease, whereas only 20 hospital days had been utilized for similar reasons in the group operated upon in the first 10 days of an attack. There have been very few instances of mistakes in diagnosis and, in those cases so labeled, the possibilities of the true diagnosis were recognized and discussed but, because of the condition and course of the patient, exploratory surgery for possible acute cholecystitis was deemed mandatory.

It should be emphasized that this approach of necessity requires sound technical skill and a firm foundation in the anatomic variations of the biliary system and related structures. Meticulous dissection, accurate delineation of the various structures and sound surgical judgment, as well as technical experience, are absolute necessities if, as in this series, common duct or arterial injuries are to be avoided.

We do not mean to imply that one should delay until the ninth or tenth day of an attack to accomplish surgical intervention. We do believe that by removing the previous 72 hour deadlines, operation for acute cholecystitis can be performed safely at the most opportune time in the patient's general course and under the optimal conditions which obtain in a hospital. There will continue to be cases of acute cholecystitis which follow a rapidly fulminating course and in which clinical judgment will dictate all due haste in surgical management.

Likewise, there will be cases where concomitant systemic disease would suggest avoidance of operative intervention if possible. In these latter instances, our plea is for the clinicians to decide before 10 days have elapsed whether their therapy is proving successful and if any question exists, to consider a simple drainage procedure like cholecystostomy, at least, before heroic measures become a necessity in the most dangerous period of all.

John J. Farrell, M.D.
professor and chairman
department of surgery
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school of medicine
Miami

Cholecystectomy in Review

Elsewhere in this issue of The Journal is an article entitled "Ten Years' Experience With Cholecystectomy" by Drs. George M. Stubbs and Thad Moseley of Jacksonville.

This paper is indeed timely and the statistical review is most enlightening. For too long, members of the medical profession have tended to procrastinate on the treatment of cholelithiasis, but one only has to review the cases recorded herein to realize that the morbidity and mortality are markedly increased in the case of the acute gallbladder as opposed to the chronic gallbladder.

Years ago, physicians used to regard the presence of stones which were asymptomatic of little consequence and the patient was told to "leave them alone unless they bother you." At the present time, unless major physical conditions preclude surgery, I believe that all patients with gallstones, whether symptomatic or not, should have a cholecystectomy.

Though this did not occur in the authors' series, exploration of the common duct does carry an increase in morbidity, and I think that one should not open the common duct unless palpable or roentgen evidence of stone or obstruction is apparent. If one will slip a polyethylene tube through the stump of the cystic duct and obtain a cholangiogram while the patient is on the operating table, many times doing so will obviate the necessity of opening the common duct unnecessarily. If one does open it, following exploration and insertion of a T tube, a cholangiogram before closure of the abdomen will tend to prevent leaving a stone behind.

The tables these authors present on complications are interesting in that they report no cases of atelectasis, but following gallbladder surgery one must always make a careful effort to see that this complication does not occur. The fact that in their series they did not have it speaks well of the nursing care furnished in the Riverside Hospital.

This is a well written paper on a most important subject and I commend it to the attention of Journal readers.

George W. Morse, M.D.
Pensacola



CLINICAL COMMENT

Diabetes Seminar

The ninth annual Diabetes Seminar was held at the Balmoral Hotel, Miami Beach, October 19 and 20, 1961. The first day's sessions were concerned with studies in diabetes, including evaluation of oral hypoglycemic agents, endocrine factors affecting free fatty acid concentration in the blood, metabolism of fructose in normal and diabetic subjects, sequelae of hypoglycemia and diabetes in pregnancy. The second day's program was concerned with problems in endocrinology and investigative work on problems in diabetes such as the value of sodium tolbutamide in diagnosis of hypoglycemic states, the significance of hyperlipemia and its responses to treatment in the diabetic patient and a study of experimentally induced leucine hypoglycemias.

Guest speakers were Dr. Stefan S. Fajans, Associate Professor of Medicine, University of Michigan Medical School, Ann Arbor, Mich.; Dr. Max Miller, Associate Professor of Medicine, Western Reserve University School of Medicine, Cleveland, and Dr. Richmond W. Smith Jr., Associate Professor of Medicine, Head of Endocrine Section, Henry Ford Hospital, Detroit. Member speakers were Dr. A. Gorman Hills, Professor of Medicine, University of Miami School of Medicine, Miami; Dr. Joel B. Mann, Instructor in Medicine, University of Miami School of Medicine, Miami; Dr. Fred Mathers, Orlando; Dr. Joseph C. Shipp, Assistant Professor of Medicine, University of Florida College of Medicine, Gainesville, and Dr. William C. Thomas Jr., Associate Professor of Medicine, University of Florida College of Medicine, Gainesville.

Studies of the oral hypoglycemic agents showed that they are still useful in treating a limited number of diabetic patients and their use must be governed by the type of diabetes and also by its severity. The main action of sulfonylurea compounds still seems to be in the production of increased insulin release although some secondary liver effects cannot be denied. The problem of secondary failure is still a matter of considerable importance, and each month a certain percentage of the patients with diabetes controlled on oral drugs have to go back to insulin, even with careful selection of patients on adequate control, and it was shown that dosage increases do not determine any increases in activity of these drugs. Moreover, the drugs must be used according to their time of action. Tolbutamide, which seems to be the safest, has a short period of action and so must be given in divided doses daily whereas chlorpropamide, having a long action of 16 to 18 hours, can be used in one daily dose. DBI, a guanidine derivative, is also used for longer periods of action, but it must be assessed carefully because of its toxic effects, particularly in the production of blood dyscrasia. It does seem useful to go with insulin in treating "brittle" diabetic patients to control the swings in the insulin effects noted in these patients. An interesting study by Dr. Fajans showed that in treating young patients with asymptomatic mild diabetes whose disease was less than eight weeks in duration or entirely asymptomatic or had been discovered in studies of familial possible diabetic persons, the use of tolbutamide for 12 to 18 months had given improvement in the glucose tolerance curve which

seemed to prevent them from going into severe childhood diabetes.

A study of the endocrine factors affecting free fatty acid concentration in the blood showed that the levels of free fatty acid in the blood, like glucose, depend on exercise, psychic distress, especially overproduction of epinephrine, and that high concentration of glucose in the blood would depress the fatty acid concentrations whereas lowering glucose would call for more fatty acid in the blood. Epinephrine and norepinephrine stimulate fatty acid release as do hypometabolism and the growth hormone of the pituitary. Insulin will suppress fatty acid production unless insulin has given hypoglycemic levels. TSH increases fatty acid concentrations while ACTH seems to have no effect. Glucagon gives reduced free fatty acid levels in the blood. Tolbutamide, like insulin, decreases free fatty acids in the blood as do increases of carbohydrate and protein in the blood. Gonadotropin hormone seemed to have no effect while the two most important factors in the varying levels of free fatty acids seemed to be the glucose levels in the blood and epinephrine releases.

Studies of fructose in normal and diabetic subjects showed that fructose can enter into fructose monophosphate and then glucose-6-phosphates in glycogen metabolism; fructose can enter into the cell without the mediation of insulin and therefore may have certain useful considerations in the treatment of diabetic acidosis and diabetic coma.

Hypoglycemia is not an unmixed blessing. In spontaneous problems of hypoglycemia due to insulinomas or overproduction of insulin by normal pancreatic islet cells or in repeated hypoglycemias or chronic hypoglycemias in diabetics, the dangers of permanent damage both to peripheral nerves and to the brain because of the deficiency of glucose in the nerve tissue must be carefully considered and for this reason overdosage with insulin should never be allowed a diabetic patient. No diabetic patient should increase insulin dosage without a doctor's advice.

A pregnant diabetic patient is a problem because toxemias are five times more frequent in the pregnant diabetic patient than in a nondiabetic pregnant patient. Antepartum care is not greatly different from that of the normal pregnancy, provided adequate insulin and diet control is maintained, but complications of pregnancy are to be expected because diabetic women have more big babies. Diabetic mothers have hydramnios 10 to 20 times more frequently, and the babies born of diabetic mothers have four times as many congenital defects. It is noteworthy that babies left to go to 40 weeks are much more likely to have defects or be associated with hydramnios; labor and delivery, therefore, are induced before 40 weeks. If conditions require delivery before 37 weeks, however, the common complications of pulmonary respiratory distress, fibrosis and hilar membrane disease are likely to develop so that inducing labor in a pregnant diabetic patient before 37 weeks is also dangerous. A most important problem in the control of the pregnant diabetic patient is the sudden and easy development of ketosis in the pregnant mother.

One interesting paper of the second day's program reported an investigation of patients with renal calculi. It was shown that there is a substance in the urine which inhibits mineralization. This is not present in those in whom stones form or those who have uremia. The absence of this substance seems to be prevalent in certain areas of the world, particularly where the soil lacks zinc and manganese. This substance does not seem to be related to the phosphorus and calcium concentrations in urine, or to infection in the urine except in the presence of urea-splitting organisms like proteus. The significance of this study is obvious.

The report on osteoporosis of the senile type showed that normal bone is present, but that there is less of it and that the disease follows a certain pattern in a certain type of person, usually the blonde, Nordic type, with a certain type of bone development. Osteoporosis seems to be an imbalance between normal bone metabolism and the lack of anabolic hormones.

A paper on hypothyroidism directed attention to the well known fact, which is frequently overlooked, that resistant anemias are often due to hypothyroidism.

The final papers of the session were devoted to the use of sodium tolbutamide in hypoglycemic states and the production and mechanism of experimentally induced leucine hypoglycemia. These studies are of importance in that they provide mechanisms to study the causes of hypoglycemia, whether spontaneous hypoglycemia of infancy or the hypoglycemia of insulinomas, and the separation of these states from the so-called idiopathic hypoglycemias. It would seem that leucine has three mechanisms of action in producing

hypoglycemia. It seems to increase production of insulin slightly, but seems to potentiate the release of insulin at its site of action and possibly in the storage of insulin. Tolbutamide is used diagnostically in hypoglycemic states because of its action in truly stimulating insulin production so that abrupt and long-continued fall of blood sugar following administration of tolbutamide may indicate true insulinoma.

Other subjects discussed were Albright's hereditary osteodystrophy and the significance of hyperlipemia in response to treatment in a diabetic patient. This latter subject was the title of the Resident Award paper which was given by Dr. John F. Monroe, of the Teaching Hospital of the University of Florida College of Medicine in Gainesville. This is an annual award presented to the resident or intern of the hospitals in Florida for the best paper on some subject related to diabetes.

On the evening of October 19, a public meeting was held with the Lay Diabetic Society of Greater Miami. An enthusiastic audience was present. The officers of the association conducted a discussion of certain diabetic problems from the viewpoint of the lay, individual, diabetic patient. A long and interesting question and answer period followed.

THEODORE F. HAHN JR., M.D.
DELAND

Florida Psychiatric Society Meeting

The interim meeting of the Florida Psychiatric Society was held October 21-22, 1961 at Grand Bahama Island. The scientific session included four papers prepared by members of the society.

William Ingram Jr., M.D., discussed the use of UML-491 (1-methyl-lysergic acid butanolamide) in the treatment of the migrainoid syndrome. This medication, known to be a serotonin blocking agent, antagonizes reserpine-induced headaches and has some of the properties of a psychic energizer. Twenty-three patients with migraine, some of whom were seriously incapacitated by their symptoms, were given the medication; good results occurred in 14. Side reactions including a coronary syndrome were discussed. The drug was considered a useful agent in treatment of the migrainoid syndrome which often is unrelieved by the usual medications.

Bernard Tumarkin, M.D., of the faculty of the University of Miami School of Medicine, presented a study of a new technique used in training psychiatric residents in group therapy. Experienced group therapists participate with the residents in tape-recorded group sessions, then meet and discuss the taped material. It was reported that this training technique was especially helpful in the area of transference and countertransference phenomena.

Victor L. Slater Jr., M.D., presented a summary of the present status of the clinical problem of alcoholism. He pointed out the magnitude of the social problem which alcoholism presents, described the usual course of the syndrome, discussed the underlying personality factors and psychodynamic mechanisms, and summarized present modes of treatment. He emphasized that diagnosis is often made late and with reluctance, though treatment results in improvement of 25 to 80 per cent of cases.

Ivan C. Berlien, M.D., of the Psychiatric Institute of the University of Miami, discussed theoretical concepts of psychic energy. He emphasized the difficulty of arriving at an ultimate understanding of mental energy and the structures or systems in which it operates. He discussed several conceptual models on which understanding of energy transactions in mental functioning can be based. Among these models were the one-celled organism, the reflex arc, computing machines, feedback systems, and the psychoanalytic concepts of mental topography, drives, defenses, and controls. He emphasized the importance of biochemical data in furthering understanding of the actual ways in which so small a system as the human brain can accomplish its enormously complex functions.

ROBERT G. ZEITLER, M.D.
TARPON SPRINGS

Annual Interim Meeting Florida Urological Society

The Seventh Annual Interim Meeting of the Florida Urological Society was held November 3-5, 1961, at The Inn, Ponte Vedra with Dr. William A. Van Nortwick, of Jacksonville, President, presiding. Dr. Robert J. Brown of Jacksonville served as chairman of the program committee and provided the members with an excellent offering.

The program was initiated by a comprehensive review of the entire subject of "Acute Renal Failure" by Dr. Arthur K. David Jr., Jackson-

ville internist. Dr. David is a member of the artificial kidney team at Baptist Memorial Hospital in Jacksonville. A lively discussion of the subject by the society members was stimulated by Dr. David's fine presentation.

The society then had the privilege of hearing Dr. William L. Valk, Professor of Urology, University of Kansas School of Medicine, Kansas City, present an analytical review of his collective experience with transurethral prostatic surgery at the University of Kansas. Dr. Valk is a well known and highly respected teacher of Urology who is a champion of the transurethral approach to the problem of bladder neck obstruction. Ninety per cent of the operations for enlarged prostate at the University of Kansas are performed by the transurethral approach. In his survey of 2,015 transurethral resections, Dr. Valk found 70 per cent had been performed for benign prostatic hypertrophy, 13 per cent for vesical neck contracture, and 15 per cent for carcinoma of the prostate. The other 2 per cent were performed for neurologic disorders and such rare growths as prostatic sarcoma and tumors metastatic to the prostate. Dr. Valk emphasized what all good urologists know, that a transurethral resection should not be construed as a procedure that does something less than an open prostatectomy, such as "cut a channel" or "ream a hole," but rather that it should perform just as complete a removal of the obstructing growth—perhaps even better —as an open procedure.

Dr. Valk also is an advocate of earlier operation for bladder neck obstruction. His figures show only a 0.4 per cent mortality on those patients below the age of 60 and 0.9 per cent mortality for those between ages 60 and 69. Conversely, he found a 4.0 per cent mortality in the age group 70 to 79 and 6.7 per cent in those 80 and above. Dr. Valk thinks that one should not wait for residual urine to develop because then the bladder muscle is decompensated. He believes that it is as unsound to wait for the bladder detrusor to decompensate before treatment as it would be to let a damaged heart muscle go into failure under one's eyes before doing anything about it.

The average weight of tissue removed was about 24 Gm. The size of the gland and the time required to remove it seemed to have little influence on mortality or morbidity unless the patient had been decompensated badly preoperatively and had an elevated blood urea nitrogen. In these "poorer candidates," the mortality was four times higher when prolonged than in those with normal blood urea nitrogen. Dr. Valk has found that those patients with elevated blood urea nitrogen do most of their improving in the first two weeks of catheter drainage. He orders a creatinine clearance at the end of two weeks. If the clearance is 50 cc. or more, he goes ahead with the transurethral resection; if not, he establishes suprapubic cystostomy drainage.

Preoperative pyelonephritis did not seem to influence greatly the mortality and morbidity in these patients, but unrecognized or tardily recognized extravasation did. There was a 1.1 per cent incidence of extravasation as a complication of the transurethral resection in this series of 2,015 patients which included the patients of the resident staff (1.5 per cent) as well as those of the attending staff (0.4 per cent). Eleven of these patients had the extravasation recognized and drained in less than two hours, and there was no morbidity or mortality as a result. In 12, it was not recognized and drained until after two hours; these patients had a 5 per cent morbidity and 4 per cent mortality.

Dr. Valk found that vas ligation dropped the incidence of epididymitis from 6.1 per cent in those who had no vas procedure to 0.9 per cent. Vas crushing did not seem worth while since patients in whom this was done still showed a 5.5 per cent incidence of epididymitis.

If a secondary resection became necessary during the same period of hospitalization, no significant increase in mortality or morbidity was noted although there was an increase in the occurrence of epididymitis.

Dr. Valk advocated the frequent use of perineal urethrotomy for introduction of the resectoscope to avoid injury to the anterior urethra.

The three major conclusions presented by Dr. Valk as a result of this study were: (1) The concept of the importance of operating time involved to perform the transurethral resection needs re-evaluation. The important consideration seems to be to do a good job rather than to do the procedure rapidly. (2) There is a profound increase in mortality of transurethral surgery with advancing age, that is, 15 to 20 times higher in the seventh and eighth decades than in the fifth and sixth. This fact plus the desirability of relieving obstruction before bladder detrusor decompensation occurs, strongly suggests that prostatic surgery, at least transurethrally, should be prescribed and carried out earlier in the natural

course of the disease. (3) Early detection and drainage of extravasation from the transurethral resection profoundly affects both mortality and morbidity.

The program continued with a panel discussion of "Renal Hypertension." Three outstanding Jacksonville specialists served as the panel; these were Dr. J. Harold Newman, urologist, Dr. Theodore L. Batchelder, vascular surgeon, and Dr. David.

The panel found the renin theory for the production of hypertension by a damaged kidney to be the theory most acceptable and pointed out that there are three broad categories of pathogenesis of renal injury leading to the production of hypertension: (1) renal arterial occlusive problems, (2) constrictive perirenal disease, and (3) renal parenchymal fibrosis resulting from any one of a number of diseases. The vascular surgeon, obviously, may be of help in the first category, and Dr. Batchelder dropped a number of pearls regarding the diagnostic techniques of aortography and outlined the ways in which the vascular surgeon can help with these problems. He indicated that the retrograde femoral approach to aortography gives the best quality films and has taken precedence over the direct, translumbar approach except in certain patients, such as those with disease of the iliac arteries, in whom it is contraindicated or in whom it cannot be used for technical reasons.

The panel pointed out that split renal function studies, that is, a disparity between urine volume and urine sodium excretion in the individual kidneys, is of great help in evaluating a possible renal basis for hypertension.

A pyelogram conference of interesting cases was presented by members of the society and presided over by Dr. Miles W. Thomley of Orlando.

DAVID W. GODDARD, M.D.
DAYTONA BEACH



MEDICAL NEWS

Fourth Annual Conference County Medical Society Presidents and Secretaries January 13 and 14, 1962

This month the Florida Medical Association will sponsor for the fourth consecutive year the annual conference of incoming presidents and secretaries of its component county medical societies. The meeting will be held at the Hotel Robert Meyer in Jacksonville on Saturday afternoon and Sunday morning, January 13 and 14. While the conference is planned especially for the presidents and secretaries at a time when they are assuming office for the new year, other county society officers will also find the program helpful. It will be to the advantage of every county society to be well represented at the meeting.

The program on Saturday afternoon will cover a broad range of subjects dealing with medical legislation, medical economics and medical services. In the evening a social hour will be followed by a buffet dinner. At the Sunday morning session, the county medical society officers will discuss their programs, projects and mutual problems.

SATURDAY, JANUARY 13 — AFTERNOON SESSION

S. Carnes Harvard, M.D., President, Florida Medical Association, Presiding

12:30 p.m. Registration

1:00 p.m. Welcome to Assembly, S. Carnes Harvard, M.D.

1:15 p.m. American Medical Association's Programs, C. Joseph Stetler, LLB, Director, Legal and Socio-Economic Division

1:50 p.m. Questions and Answers

2:00 p.m. Medical Legislation (National and State), Edward R. Annis, M.D., Chairman, Committee on State Legislation

2:50 p.m. Questions and Answers

3:00 p.m. Recess

3:15 p.m. Medical Economics, Henry J. Babers Jr., M.D., Chairman, Committee on Fee Schedules

3:50 p.m. Questions and Answers

4:00 p.m. Medical Services, Samuel M. Day, M.D., Secretary-Treasurer

4:30 p.m. Questions and Answers

6:30 p.m. Refreshments

7:30 p.m. Buffet Dinner

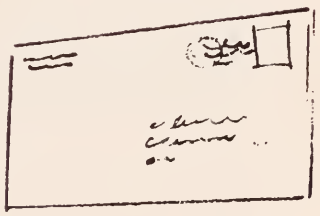
SUNDAY, JANUARY 14 — MORNING SESSION

Robert E. Zellner, M.D., President-Elect, Florida Medical Association, Presiding

9:00 a.m. to 12:00 noon Morning session will be devoted to county medical society officers for discussion of their programs and problems.

12:00 noon Adjournment

LETTERS



December 6, 1961

Dear Dr. Moseley:

We have read with considerable interest, the editorial comments related to our paper on "Newer Methods for the Detection of Congenital Cardiac Shunts." The paper was published in the December, 1961, issue of The Journal of the Florida Medical Association and the editorial comments by Dr. Myron Wheat, Jr. were published in the same December issue. It is apparent from these comments that considerable misunderstanding exists in the mind of the editorial writer. We should like to take this opportunity to emphasize our position.

The purpose of this paper was elucidation of general principles of indicator dilution curves and as such, this paper was addressed to a general medical audience *at the annual meeting of the Florida Medical Association* in May, 1961. This paper was not addressed to, nor was it designed for, a specialized group of cardio-pulmonary physiologists. The approach was, of necessity, broad since it was directed at a heterogenous medical group. The editorial writer has apparently failed to recognize this point.

Nowhere in the paper do we state that we have "discarded the less accurate oxygen technique completely," as stated by the editorial writer. On the contrary in our laboratory, the nitrous oxide and blood oxygen content methods are always employed to complement the dye method. Only a clinician or physiologist with limited perspective would be wedded to one technique.

With regard to the comment by the editorial writer of "a young boy with Eisenmenger complex"—we well recognize that the Eisenmenger complex usually has a right to left as well as a left to right shunt. In figures 2a and 2b of our paper there is clear demonstration that a right to left as well as a left to right shunt exists in this young patient. The editorial writer has unfortunately

not recognized that figure 2b is from the same patient as figure 2a and that a mixed shunt is therefore present in this patient. The left to right shunt was demonstrated in this patient by the nitrous oxide, as well as the oxygen content technique.

In over 200 cases employing the indicator dilution technique with indocyanine green during cardiac catheterization, we have never been confronted with the problems of coronary sinus ostium injection. Furthermore it is well known to experienced cardio-pulmonary physiologists, that indicator dilution injections are made into both the right atrium and the superior vena cava in order to compare dilution curves from both injections sites. Such an approach obviates the potential (but in our experience non-existent) problems mentioned by the editorial writer.

Nowhere in the paper have we stated that a right to left shunt after superior vena cava injection automatically means a sinus venosus defect as stated by the editorial writer. We instead used the term "highly suggestive." Furthermore in the case cited the right to left shunt was much greater from the superior vena cava than after inferior vena cava injection, a situation which is the obverse of that seen in an ostium secundum defect. In the latter defect if a right to left shunt is present from both the superior and inferior venae cavae, the right to left shunt is larger from the inferior vena cava. Usually little if any right to left shunt is present from the superior vena cava in ostium secundum defect.

With regard to the comment about indicator dilution curves done after right atrial and left atrial injection in total anomalous pulmonary venous drainage, the upstroke contour and appearance time of the curve after right and left atrial injection are similar as can be seen by inspection of figure 7c and d. A break on the downstroke of the right atrial curve but not on that of the left atrial curve is the only difference in these two curves. The indicator dilution curve merely gives a pathway of distribution of indicator material. Dye injection into the left atrium results in a mixture of this material with blood from the right atrium before the indicator passes to the systemic peripheral arterial tree. Since the only source of blood for the left atrium derives from the right atrium, there must, of mathematical necessity, be considerable similarity of right atrial and left atrial curves. These observations have of course been well documented by other investigators.

One area in the editorial with which we are in full agreement is the statement that "Dr. Wood and his group at the Mayo Clinic have certainly made an outstanding series of contributions in this respect." There is no published bibliography in our paper in the December issue of The Journal of the Florida Medical Association, because this paper was presented, as noted above, at the May, 1961 meeting. In other papers from this laboratory we have acknowledged the outstanding work of Dr. Wood and his group at the Mayo Clinic, and Dr. Eugene Braunwald and his group at the National Heart Institute at Bethesda, Maryland. Since the editorial writer elected to include a bibliography, mention of the nitrous oxide and Krypton inhalation techniques developed by Dr. Braunwald and his group, the hydrogen inhalation and hydrogenated saline injection techniques developed by Dr. Clark at the University of Alabama and Dr. Hyman at Tulane University, as well as the ascorbic acid technique utilized by Dr. Braunwald and Dr. Clark would have been appropriate. Dr. Clark and his group have also recently utilized the oxygen tension (as opposed to the blood oxygen content) approach with considerable success. Radioactive alkyl iodides and I^{131} tagged albumin have also proven to be useful indicators. Hypertonic saline and solutions above or below body temperature may also be utilized to record indicator dilution curves. A complete discussion of indicator dilution techniques today thus includes a variety of agents. Indeed the contrast materials employed in angiocardiography constitute only one of the variety of indicator dilution techniques. The result of these varied approaches to indicator dilution techniques has been a decreasing reliance placed upon the blood oxygen content method in progressive cardio-pulmonary laboratories.

In closing, we regret the necessity to go into the minutiae of indicator dilution techniques. However, the editorial comments of Dr. Wheat require that we do so. We respectfully request that the foregoing comments be published in their entirety in The Journal of the Florida Medical Association.

Respectfully submitted,
(Signed)
Philip Samet, M.D., Director
Cardio-Pulmonary Laboratory
Mount Sinai Hospital
Associate Professor of Medicine
and Physiology, University of
Miami School of Medicine





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1. Sollmann, T.: A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology, ed. 8, Philadelphia, W. B. Saunders Company, 1957, p. 206.

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Research in the Service of Medicine

REPORTS

Report of Delegates American Medical Association 1961 Clinical Meeting

At the Fifteenth Clinical Meeting of the American Medical Association, held in Denver on November 26-30, 1961, Social Security health care, relations with the American College of Surgeons, organization of the American Medical Political Action Committee (AMPAC), medical discipline and polio vaccine were among the major subjects upon which the House of Delegates took action.

In his address, sounding the keynote for the Association's campaign to oppose enactment of the King-Anderson type of legislation in 1962, President Leonard W. Larson declared that proposals to incorporate health care benefits into the Social Security system "would certainly represent the first major, irreversible step toward the complete socialization of medical care." The House of Delegates gave enthusiastic approval to Dr. Larson's address and took several actions reaffirming strong support for the Kerr-Mills program to aid the needy and near needy aged, and urging a concerted, determined fight against Social Security health care proposals in the Congress. In addition, the House advised all state and county medical societies to recognize the impending threat and to prepare now for any eventuality.

The House agreed with the intent of five resolutions which expressed strong dissatisfaction over recent statements by a spokesman for the American College of Surgeons. It gave approval to arrangements which had been made for a January meeting to discuss that organization's recent statements and policy positions with its Board of Regents in the hope of leading "to a unification of effort in behalf of American medicine."

The purpose and goals of the recently organized American Medical Political Action Committee (AMPAC), an organization separate and distinct from the American Medical Association as required by law, were heartily approved by the House. This new organization was formed in recognition of "the need for a national medical political action committee to coordinate the political activities of physician groups at all levels throughout the country. The House urged all physicians, their wives and interested friends to join this committee and other political action committees in their states and communities.

A proposed amendment to change the bylaws so as to confer original jurisdiction on the Association to suspend and/or revoke membership of a physician found guilty of violating the Principles of Medical Ethics or the ethical policies of the Association, regardless of whether or not action had been taken against him at the local level, was referred back to the Council on Constitution and Bylaws. Approval was given to the expanded activities of the Judicial Council, which has taken over permanent responsibility in the area of medical discipline.

The House adopted a resolution urging societies at the state level and below to encourage, stimulate and participate in surveys to determine the percentage of individuals in each community who have undergone immunizing procedures for poliomyelitis and on the basis of the results to determine at the local level the type of vaccine and the most effective program which will be of greatest benefit to the public. The resolution designated the Salk vaccine as the vaccine of choice for routine poliomyelitis immunization until all three types of oral vaccine are available, with the choice of program for administering the vaccine to be determined on a local basis by each county medical society.

Among its numerous other actions the House agreed with the Judicial Council that the physician himself is responsible for the control and custody of drug samples once they come into his possession; reaffirmed the previous policy that physicians should have the privilege of prescribing drugs by either generic or brand names; endorsed the administration of indigent medical care programs developed in cooperation with local medical organizations as a legitimate activity of state and local health departments; urged the elimination

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of all "categories" in programs of assistance to the needy at the federal and state level, with all assistance provided through a single program; urged more vigorous promotion of voluntary non-profit prepayment health plans; and urged every physician in the United States to use automobile seat belts.

Of particular interest to Florida physicians was approval of the choice of Miami Beach as the site for the 1964 Clinical Meeting. The final registration at the Denver meeting was 6,138, including 2,976 physicians.

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NEWS

The twenty-fifth annual meeting of the New Orleans Graduate Medical Assembly is being held March 12-15 at New Orleans with headquarters at the Roosevelt Hotel. The program, in which 19 outstanding guest speakers will participate, includes 55 informative discussions on many topics of current medical interest and in addition clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

The Post Graduate Cardiac Surgical Colloquia of the Section of Thoracic and Cardiovascular Surgery of the University of Miami School of Medicine will continue in March and April. On March 10, Dr. Andrew G. Morrow, Chief, Clinic of Surgery, National Heart Institute, discusses "Surgical Consideration in Congenital Left Ventricular Outflow Tract Obstruction," and on March 24, Dr. William H. Muller Jr., Professor and Chairman, Department of Surgery, University of Virginia School of Medicine, will conduct a conference on "Considerations of the Clinical Use of Cardiac Valve Prostheses." On April 14, Dr. Denton A. Cooley, Associate Professor of Surgery, Baylor University College of Medicine, will discuss "Open Heart Surgical Techniques and Problems in Infants," and on April 28, the Colloquia will be concluded with a conference on "Surgery of the Coronary Circulation," by Dr. David C. Sabiston Jr., Associate Professor of Surgery, Johns Hopkins University School of Medicine.

Dr. Charles K. Donegan of St. Petersburg has been chosen by the Board of Trustees of the American Society of Internal Medicine to succeed Dr. George K. Weaver of Stockton, Calif., as president-elect of the Society. Dr. Donegan has been serving on the Board since 1959.

The Sixteenth Annual Florida Midwinter Seminar of Ophthalmology and Otolaryngology is being held January 29 through February 3 at the Americana Hotel, Miami. The Seminar is presented in cooperation with the University of Florida College of Medicine and the University of

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Miami School of Medicine. Lecturers in ophthalmology appearing January 29-31 are Drs. A. B. Reese, Byron Smith and Donald M. Shafer of New York City; Dr. Lorenz E. Zimmerman of Washington, D. C., and Dr. Albert E. Sloane of Boston. Lecturers in otolaryngology giving presentations February 1-3 are Dr. Charles M. Norris of Philadelphia; Dr. G. O'Neil Proud of Kansas City; Dr. J. Ryan Chandler of Miami; Dr. Stanton A. Friedberg of Chicago, and Col. Paul A. Campbell (MC) of Brooks Air Force Base, Texas.

Dr. Kenneth S. Whitmer of Miami has been elected vice chairman for ophthalmology and Dr. James R. Chandler Jr. of Miami vice chairman for Otolaryngology of the Section on Ophthalmology and Otolaryngology of the Southern Medical Association.

Dr. Richard T. Farrior of Tampa will be a guest speaker at the Thirty-Fifth Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties of the Gill Memorial Eye, Ear and Throat Hospital being held April 2-6 at Roanoke, Va.

Dr. Earl R. Fox of St. Petersburg has been elected chairman of the Board of Directors of the Florida Chapter of the Arthritis and Rheumatism Foundation. Dr. Sanford A. Mullen of Jacksonville has been elected vice president.

Dr. George T. Harrell of Gainesville, Dean of the University of Florida College of Medicine, served as chairman of the special committee which prepared the "Guide to Planning Medical School Facilities," a new publication of the U. S. Public Health Service's Division of Hospitals and Medical Facilities.

Dr. S. Carnes Harvard of Brooksville, President of the Florida Medical Association; Dr. Ralph S. Sappenfield of Miami, Vice President; Dr. Eugene G. Peek Jr. of Ocala, Vice Speaker and Drs. Reuben B. Chrisman Jr. of Coral Gables, Francis T. Holland of Tallahassee, Meredith Mallory of Orlando and Burns A. Dobbins Jr. of Fort Lauderdale, Delegates, and Dr. Ralph W. Jack of Miami, a member of the Board of Governors, attended the Clinical Session of the American Medical Association held the last of November at Denver, Colo.

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The Escambia Pediatric Society for a series of meetings the middle of October had as guest speaker Dr. E. B. D. Neuhauser, Professor of Radiology and Radiologist-in-Chief of the Children's Hospital Medical Center in Boston, according to a report by Dr. Franklin L. DeBusk of Pensacola, secretary of the Society.

Dr. Kenneth A. Morris of Jacksonville has been elected vice president of the Southern Surgical Association. He was one of the presiding officers at the recent meeting held at Hot Springs, Va.

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The Eighth Annual Central Florida Medical Meeting, sponsored by the Orange County Medical Society, and the Third Annual Cardiovascular Seminar, sponsored by the Orange County Heart Association and the Northeast Florida Heart Association, have been combined into the Cardiology and Endocrinology Symposium being presented February 2-3 in the Auditorium of the Cherry Plaza Hotel at Orlando.

MEETINGS

January

Seminar in Obstetrics and Gynecology, Jan. 11-12, College of Medicine, University of Florida, Gainesville

Conference of County Medical Society Presidents and Secretaries, Jan. 13-14, Hotel Robert Meyer, Jacksonville

Seminar in Pediatric Surgery, Jan. 25-27, College of Medicine, University of Florida, Gainesville

Midwinter Seminar in Ophthalmology and Otolaryngology, Jan. 28-Feb. 4, Hotel Americana, Miami Beach.

February

Cardiology and Endocrinology Symposium, Feb. 2-3, Cherry Plaza Hotel, Orlando

Fourth Annual Cardiovascular Seminar, Feb. 17-18, Hawaiian Village Motel, Tampa

March

Post Graduate Cardiac Surgical Colloquia, March 10 and March 24, Pathology Conference Room, Jackson Memorial Hospital, Miami

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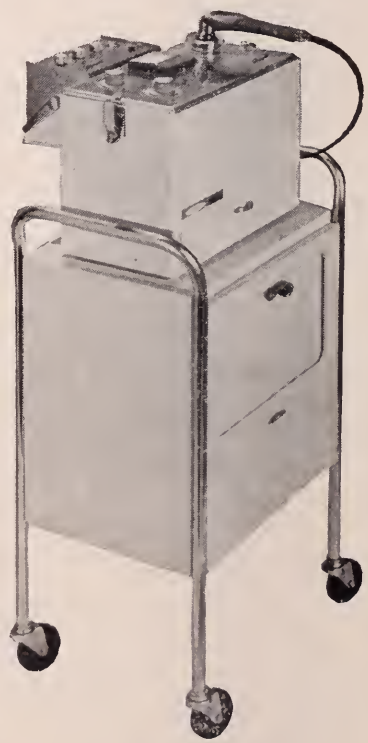
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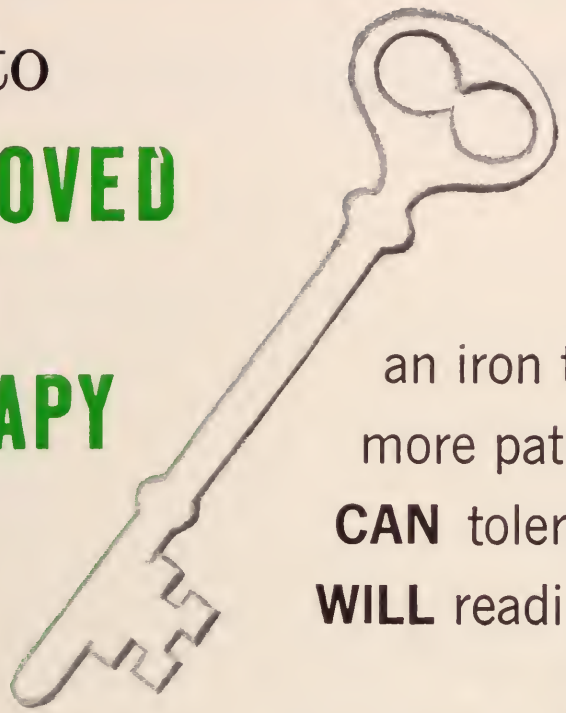
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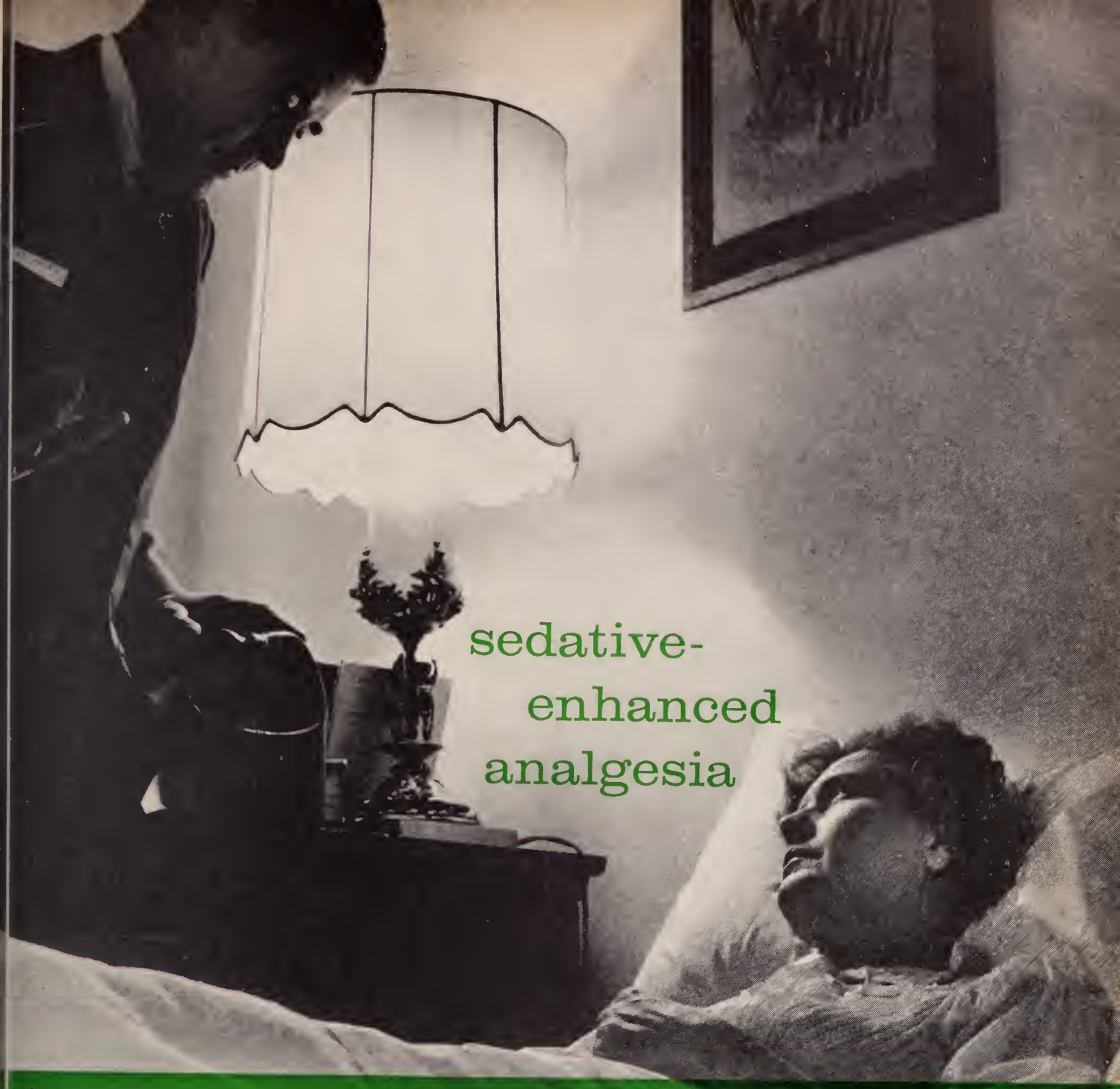
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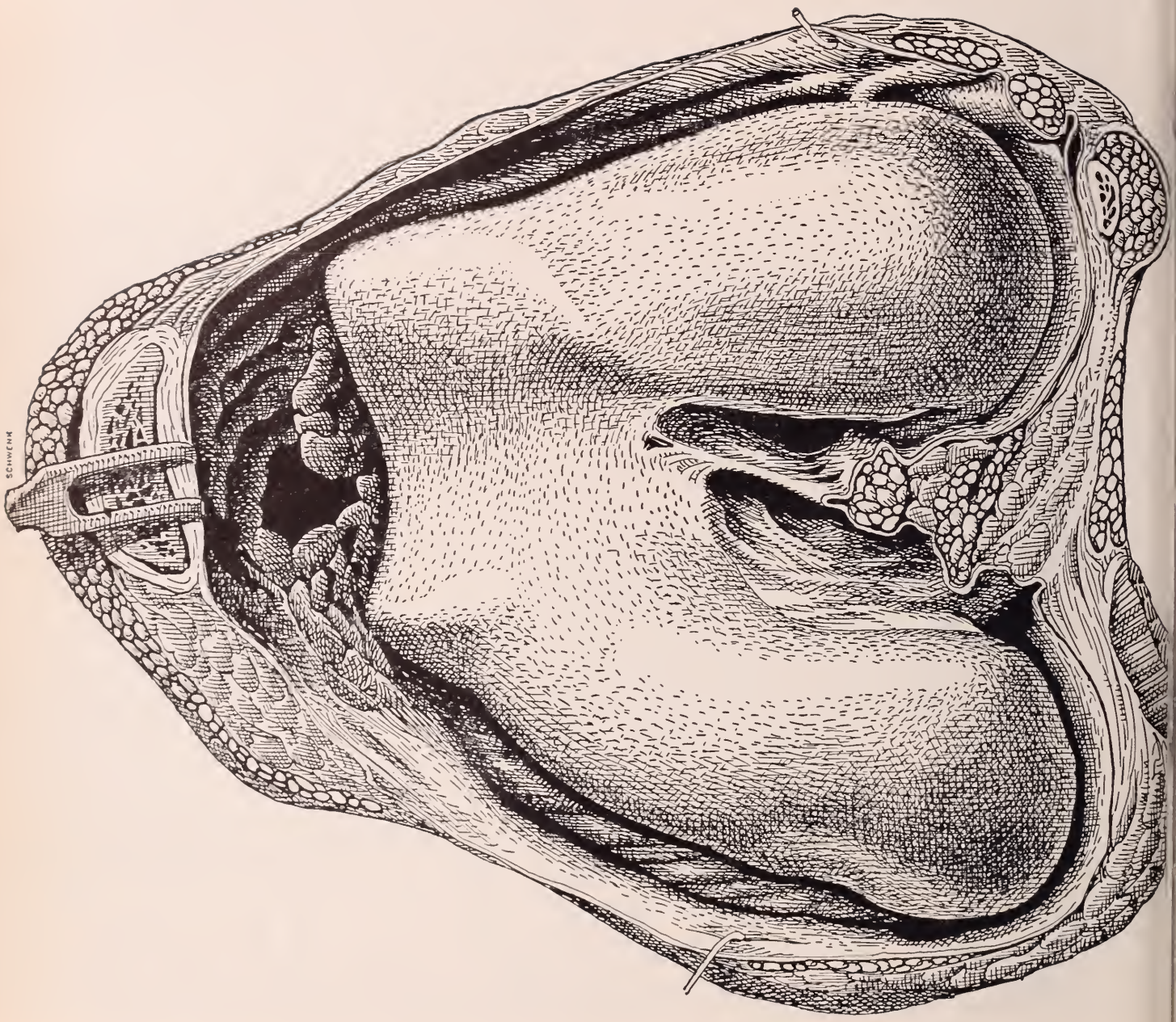
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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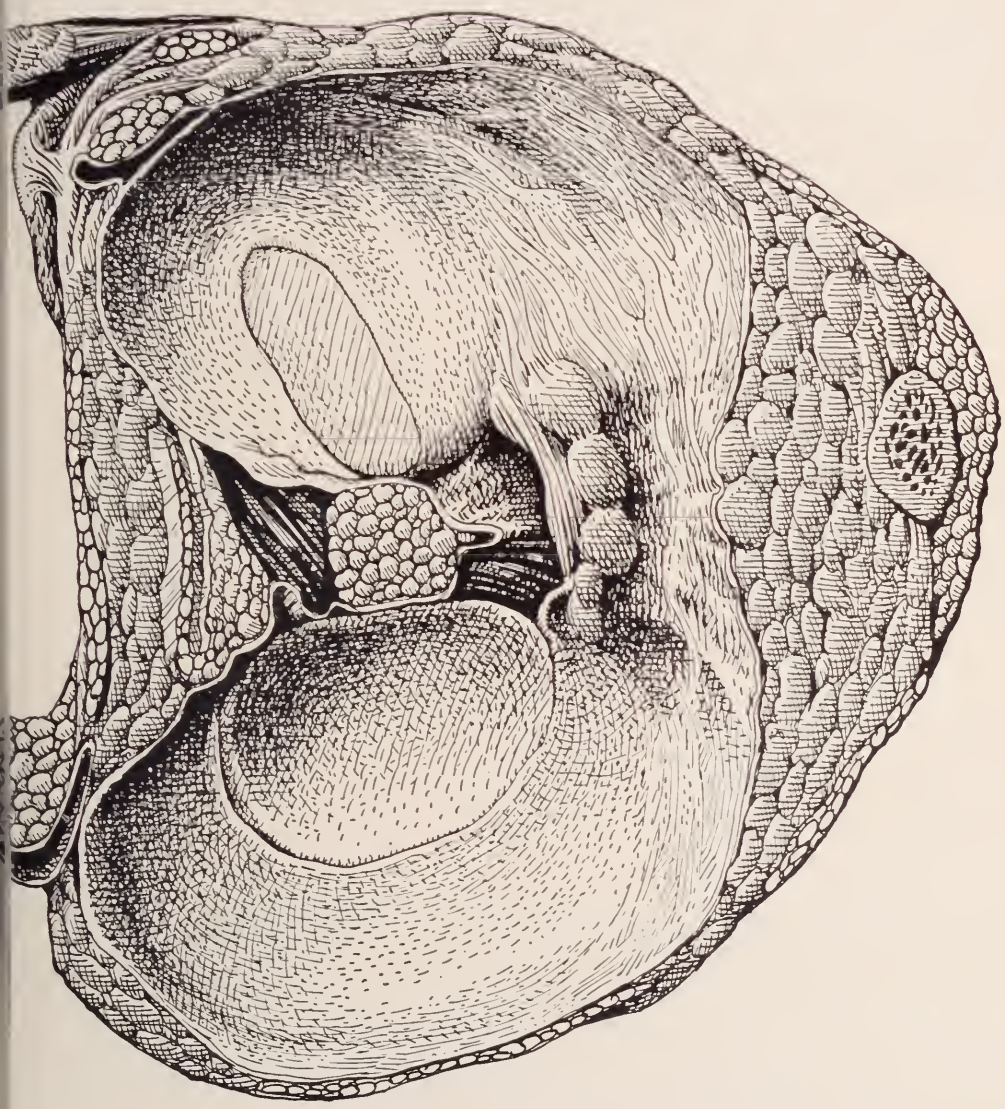
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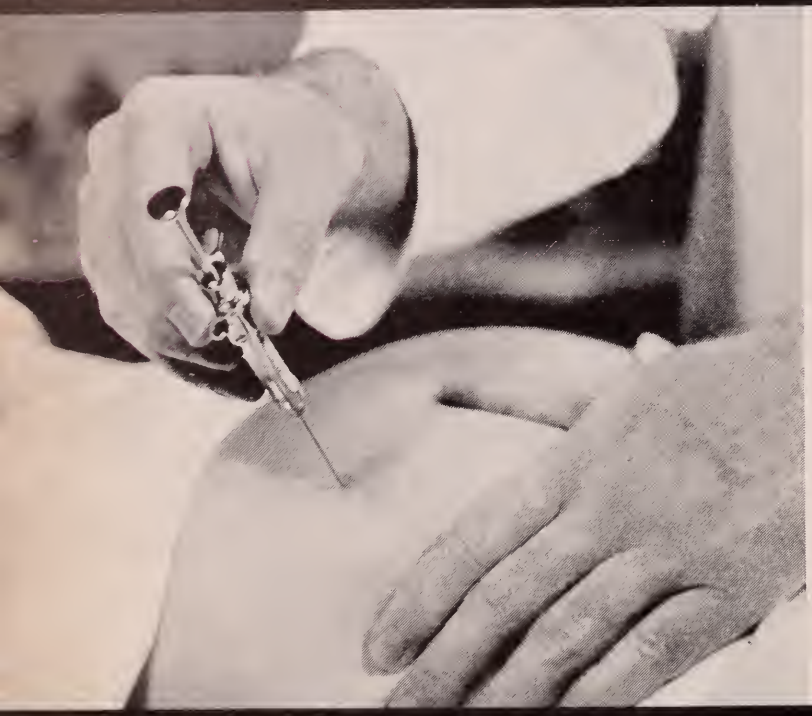
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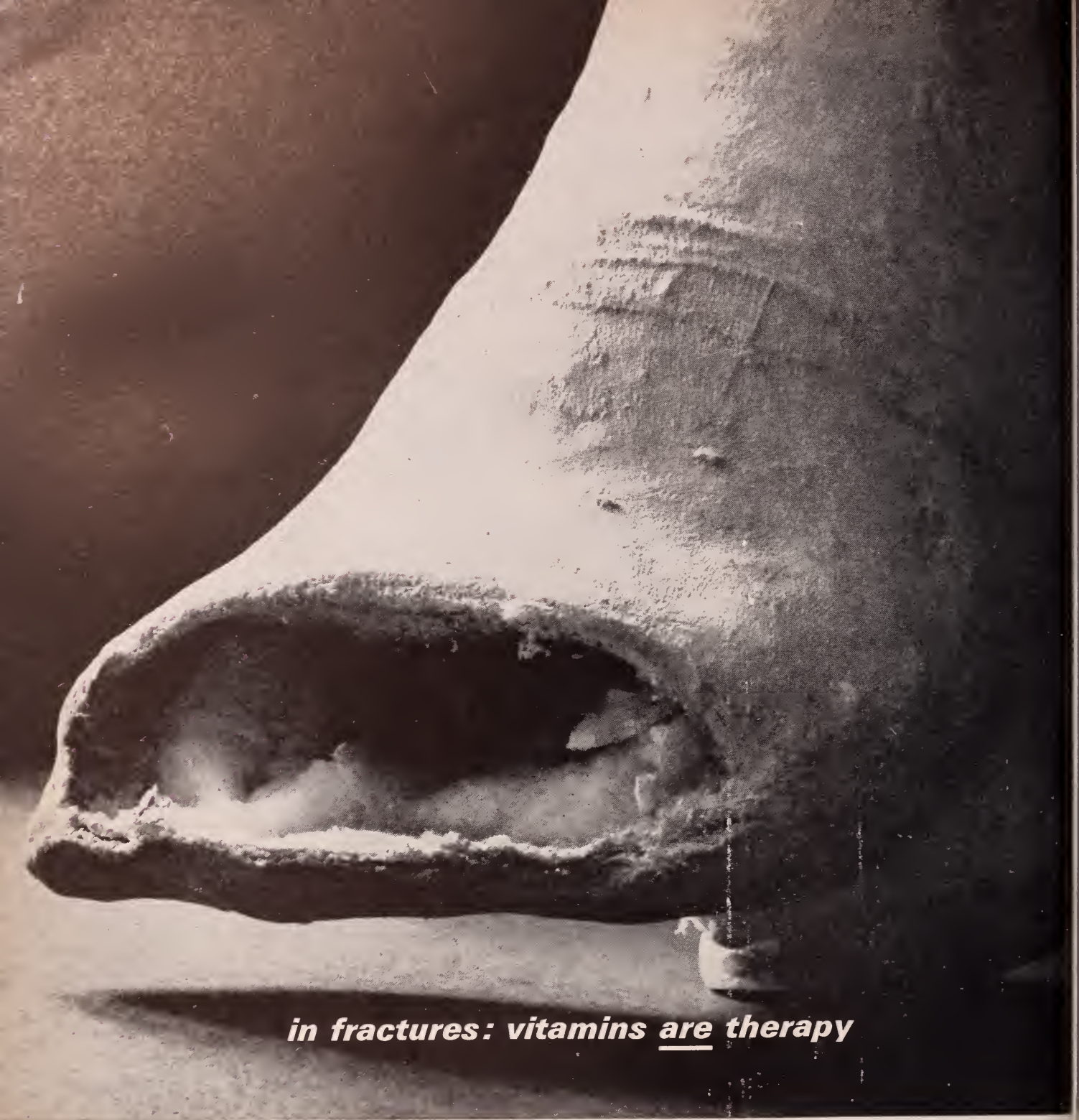
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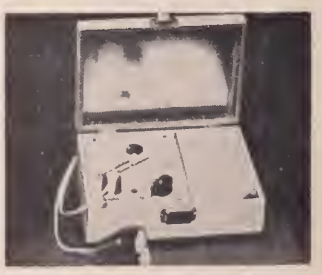


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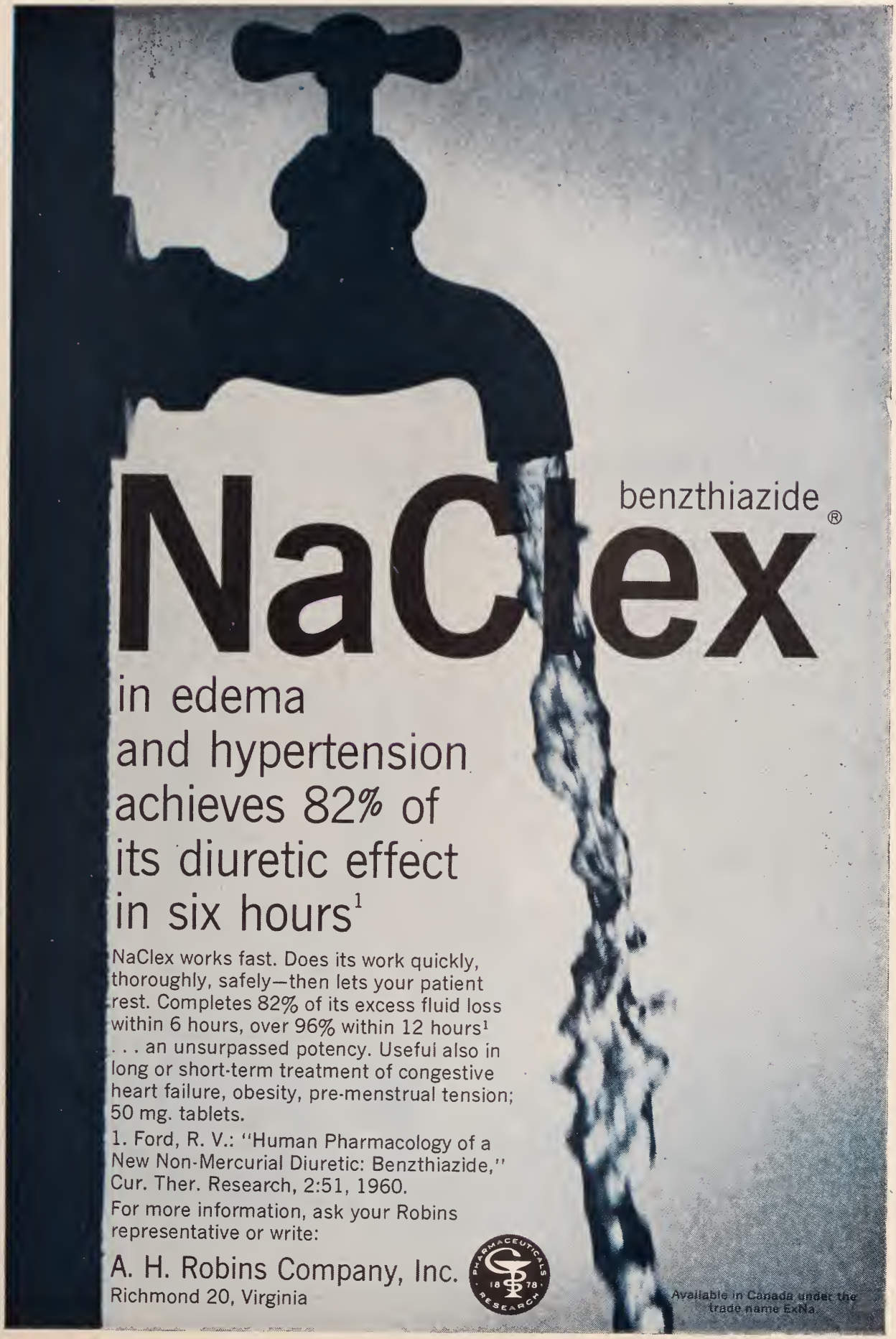
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.. Am. J. Med. 25:662 (Nov.) 1958

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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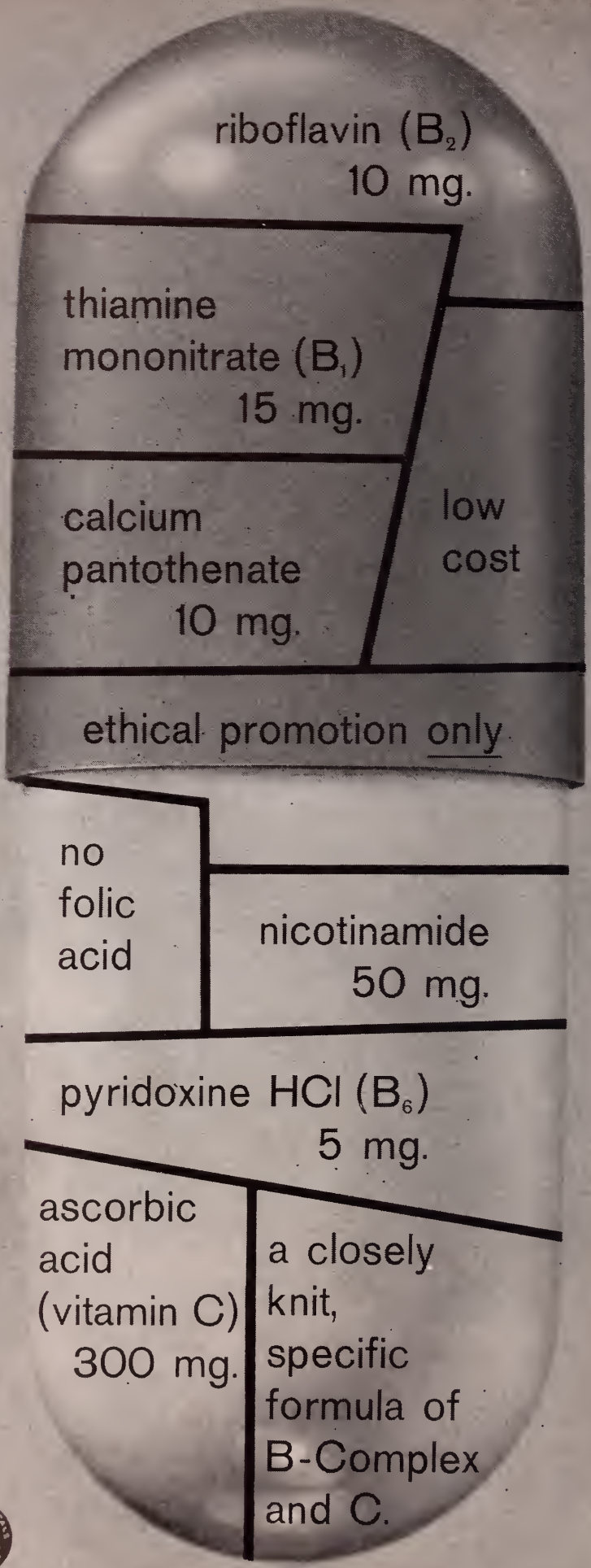
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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(chloramphenicol, Parke-Davis)

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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February, 1962

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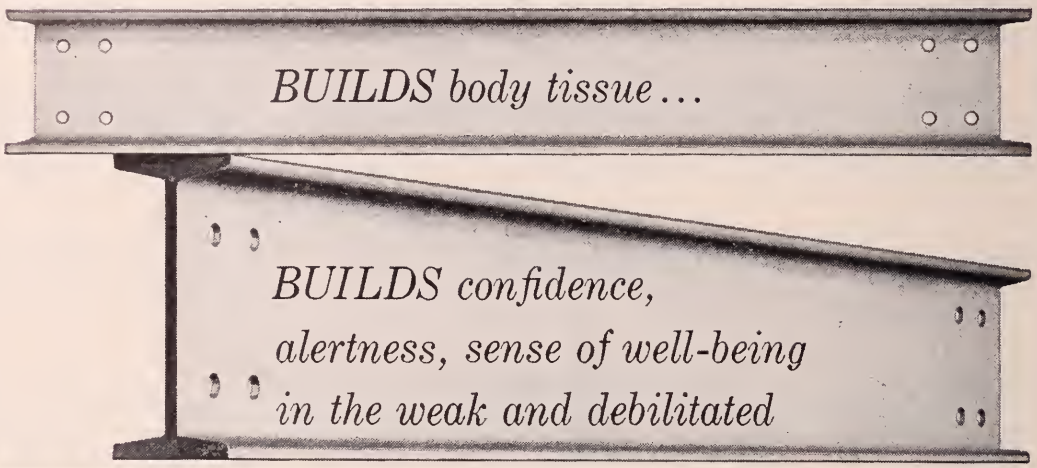
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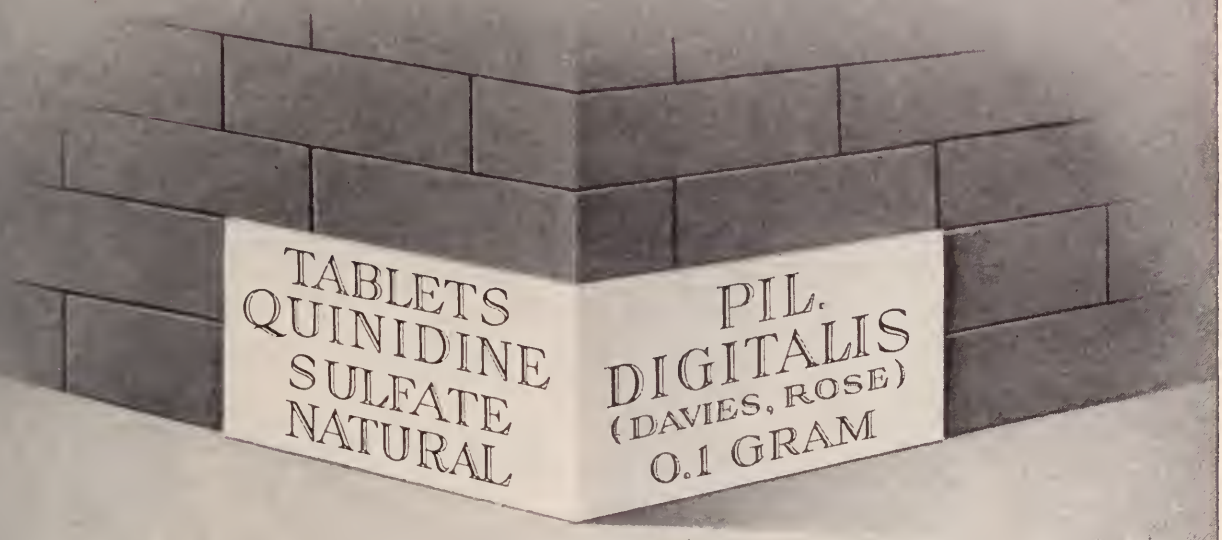
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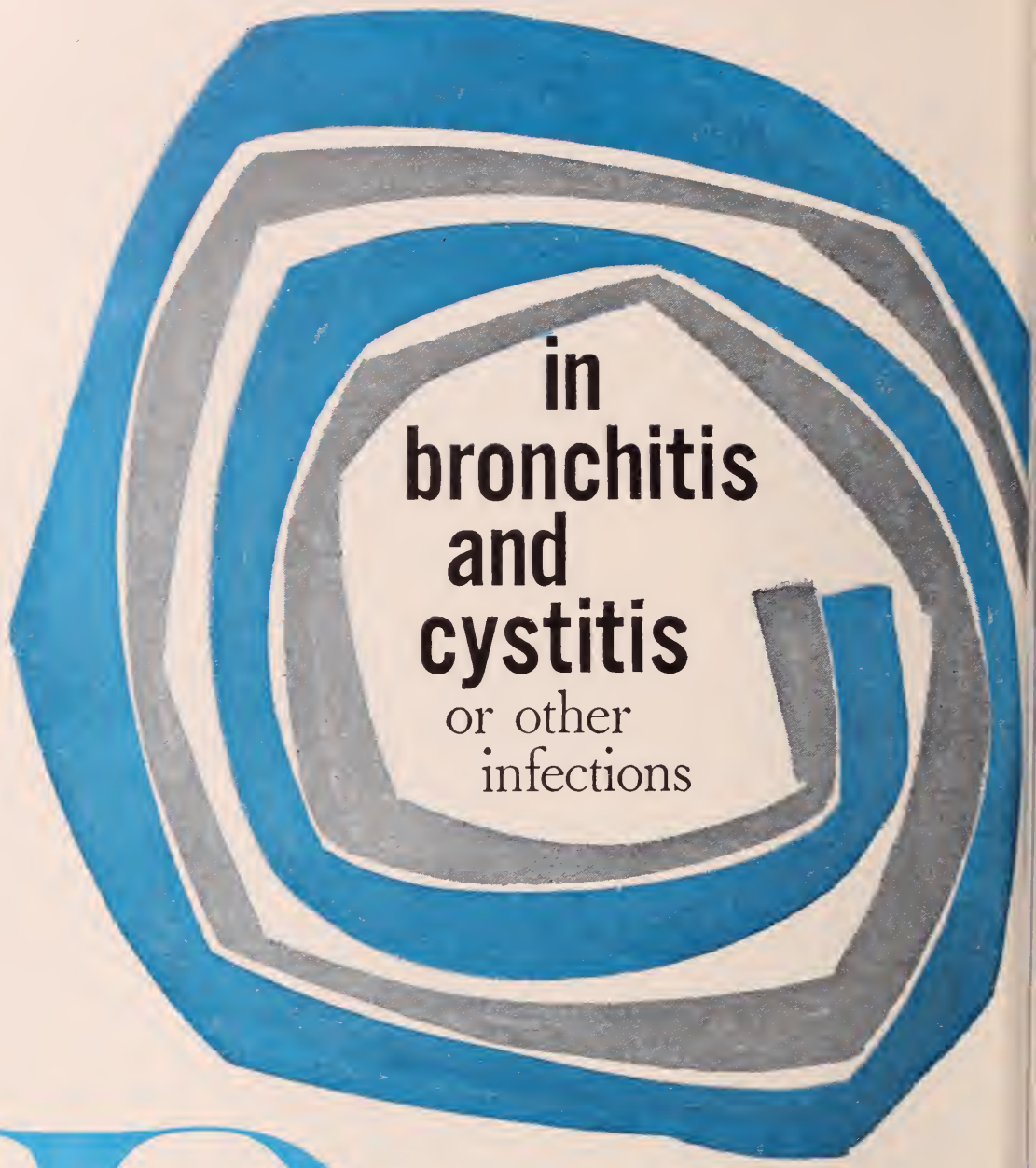
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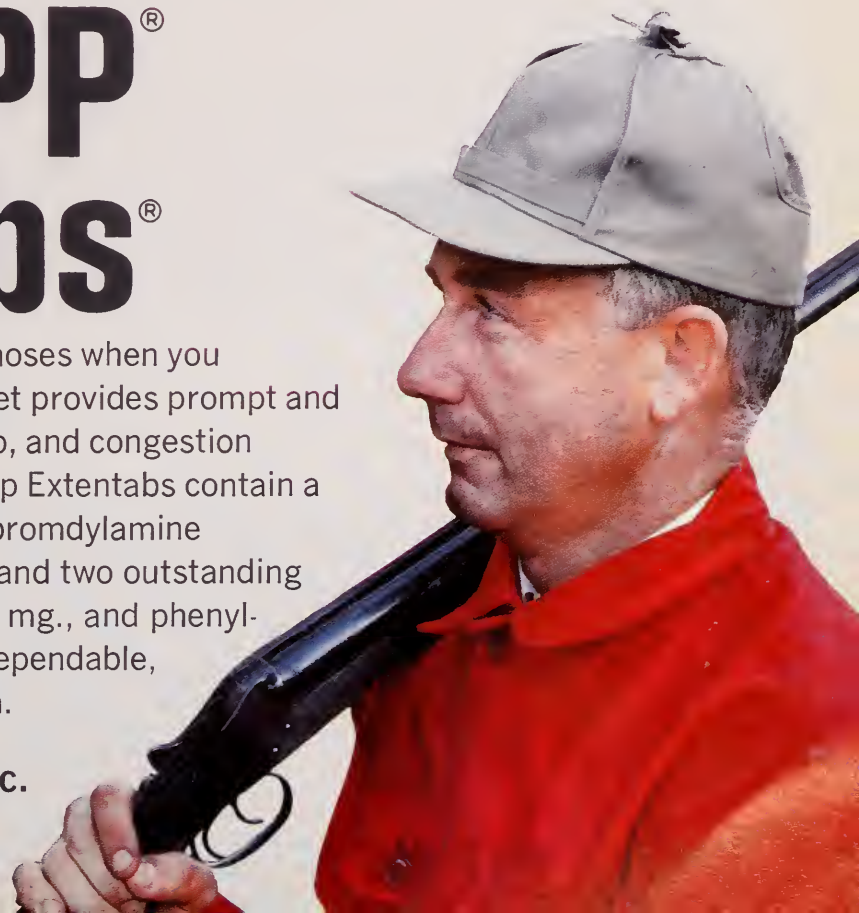
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rst of all, what does "rigid-ring" mean?

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eories are all right, but is Robanul ally more selective?

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w is it for reducing gastric acid?

e investigator[1a] found that a 2 mg. dose of Robanul ered acid secretion 73% in one hour (compared to asal-hour period) and 84% in two. A 4 mg. dose pped secretion over 94% in one hour and 97% in two!

at about acidity, or concentration of acid?

one study, glycopyrrolate produced significant sup-ssion of pH to 4.5 or higher in 5 of 5 duodenal ulcer ients given a 4 mg. dose, 7 of 8 patients given 2 mg., 4 of 5 patients given 1 mg.[1b]

Robanul depress gastric hypermotility?

nother study[2] with six subjects Robanul decreased tric motility in every patient. Within 40 minutes after administration of 2 mg. of Robanul, the frequency of tric antral contractions decreased from 1 every 24 seconds to only 1 every 2½ minutes. Young and Sun[1c] found a similar effect. Moreover, their results in 7 patients indicated that Robanul, in a dose of 2 mg., did not produce delay in gastric emptying or intestinal transit.

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References: 1. From the New York Academy of Sciences, Conference on Peptic Ulcer, Oct., 1961. (a) H. C. Moeller. (b) D. C. H. Sun. (c) R. Young and D. C. H. Sun. 2. W. C. Breidenbach: Investigative clinical report, March, 1961. 3. I. A. Feder: Investigative clinical report, May, 1961.

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1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

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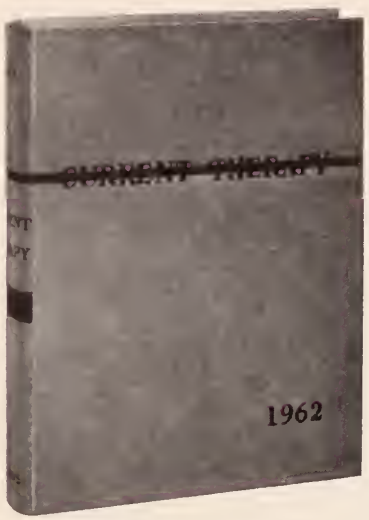
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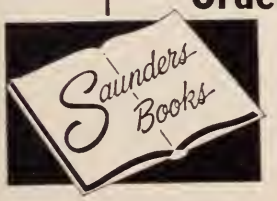
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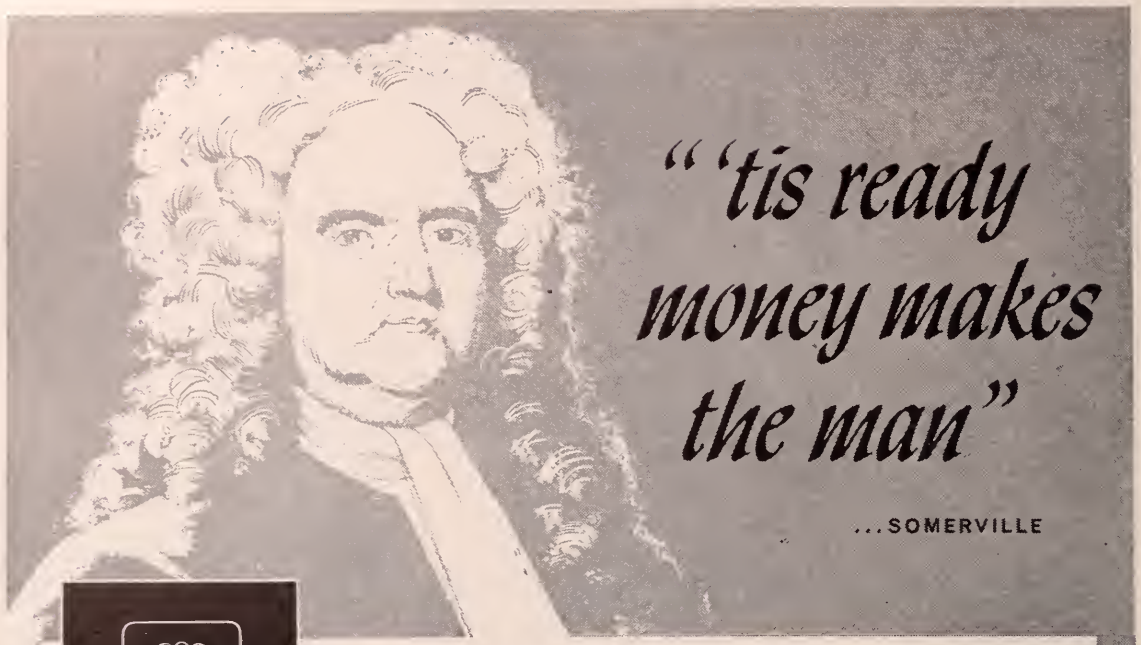
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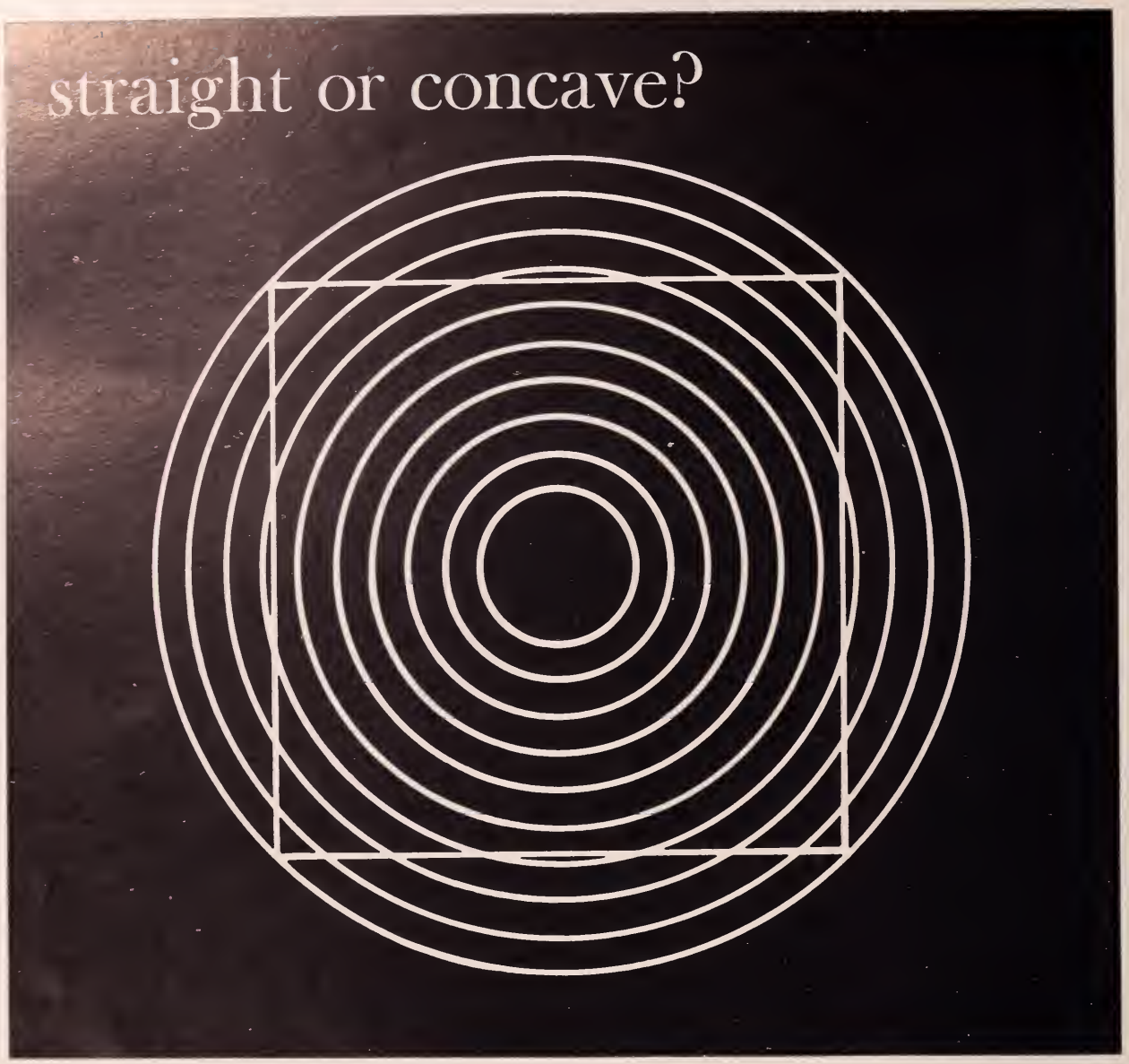
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Hypertension and Unilateral Renal Disease

ROBERT S. HOTCHKISS, M.D.
NEW YORK CITY

One hundred and thirty years ago Richard Bright[1] first related hypertension to renal disease, and as early as 1879 numerous experiments were performed on animals to produce artificial hypertension by manipulation of the kidney or its blood vessels. Transient periods of elevated blood pressure were obtained in that early period of experimentation by compression of renal arteries or of the kidney itself, and by partial nephrectomy. Clinical interest was rekindled by Goldblatt, Lynch, Hanzel and Summerville[2] in 1934 when they reported that chronic partial constriction of the main renal arteries in the dog, at times, produced sustained hypertension. Renal physiologists developed analytical methods to measure the various parameters of renal function, and it would appear that means and knowledge were, at last, available to help the 25 per cent of the population above the age of 40 who have hypertension.[3] As yet there is no cure for the vast majority of those so afflicted, but it is now established that unilateral renal disease is definitely one of the few known remediable causes of hypertension and the recognition of patients in whom such a lesion exists is an accomplishment of major importance.[4]

The identification of such hypertensive patients who may be cured, or greatly benefited, by surgery is a complicated clinical investigation. The diagnostic maneuvers involve the experience and abilities of several persons working as a team, and the patient proceeds through a series of examinations and tests which are, of necessity, expensive and not without danger. Unfortunately there is no simple screening technique, and for these reasons alone, only a small proportion of hypertensive patients could be completely examined even if such seemed desirable. It may be profitable, therefore, to review the steps currently used to diagnose unilateral renal disease as a cause of hypertension.

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Read before the Florida Medical Association, Eighty-Seventh Annual Meeting, Miami, May 27, 1961.

Because of the absence of Dr. Hotchkiss, this paper was read by Dr. James F. Sullivan, Associate Professor of Urology, Post-Graduate Medical School, New York University, New York City.

I. History

A review of the successful results from surgery upon the kidney or its blood vessels demonstrates that the highest percentage of cures was in those patients who (1) had a short history of hypertension, (2) had a rapid course, (3) were under 30 years of age (4) had a diastolic pressure of 130 mm. Hg or more and (5) had evidence of pre-existing pyelonephritis. Only a very few patients are able to contribute useful information which alerts one to suspect a disease of this type in one kidney. A sudden sharp pain in the loin in a patient having rheumatic carditis, periarteritis nodosa, or auricular fibrillation may indicate a renal infarct. If this is complete, it is less apt to produce hypertension than if partial. A report of severe renal trauma might be of significance for renal ischemia may result from contractile scars. Thus, some selectivity is possible from the history, but most patients have no symptoms indicative of renal disorders and may or may not offer complaints usual to the hypertensive state.

II. Physical Examination

Usually the physical examination discloses only those findings characteristic of hypertension. In exceptional and rare instances a bruit is audible by auscultation over one or both costovertebral angles suggesting an aneurysm of the renal artery. The discovery of conditions which ordinarily classify a person as a "urologic patient" may be unrewarding in general, for a comparison of urologic patients with a control group disclosed an equal incidence of hypertension in each.

III. Intravenous Pyelogram

The excretory pyelogram is an important tool in the hypertensive patient even though such urograms may appear entirely normal in the presence of significant renal and vascular disease. A normal intravenous pyelogram, therefore, should never be used to exclude a patient from further study. Three aspects of pyelography deserve particular emphasis.

1. Differences in Size of the Two Kidneys.—Measurements of the length and width of the renal parenchyma should be ascertained whenever the outline is sufficiently distinct to do so. The smaller kidney becomes suspicious for as Howard, Berthrong, Gould and Yendt[5] pointed out, the reduction in size may represent ischemic contraction.

2. Calcifications.—Annular calcification in the region of the renal pedicle may be highly significant for this may well represent aneurysm of the artery. Linear calcifications to the left of the lumbar spine should not be overlooked because aortic aneurysm may be a complicating factor.

3. Concentration of Contrast Medium.—Delay in appearance of or absence of contrast medium on one side as compared to the other may, of course, represent lowered renal function. We have noted, however, an earlier concentration equal to that of the opposite kidney. Baldwin[6] attributed this seeming contradiction to the preservation of tubular excretory function so that the rate of dye excretion is equal in the two kidneys, giving a higher concentration of dye in the urine from the offending kidney with impaired sodium excretion and lowered urine volume.

IV. Tests for Extrarenal Sources of Hypertension

Tumors of the adrenal must be considered in every case of hypertension for a sustained hypertension from a pheochromocytoma may be indistinguishable from essential hypertension unless clinical and pharmacological tests are applied. This discussion, however, is outside the scope of this presentation.

V. Adjunctive Tests for Differential Renal Function

A test for differential renal function has been described and applied by Winter, Maxwell, Rockney and Kleeman,[7] utilizing tracer dose I^{131} injected intravenously. The vascular filling and subsequent tubular concentration and a third emptying phase are recorded by scintillometers placed simultaneously over each kidney. This test gave great promise because of simplicity and absence of complications; yet errors in both false negative and false positive results have mitigated against its use as a convenient screening device. Newer ionized compounds are under test which may eventually be more specific.

VI. Comparative Split Renal Function Tests

In 1951 Mueller, Surtshin, Carlin and White[8] reported that renal artery stenosis in the dog would result in decreased sodium excretion and reduced urine output. Howard and his associates[5] in 1954 suggested that a comparison of the urine volume and sodium concentration of the separate kidneys might be of diagnostic value as to a cause of hypertension. They postulated the principle that if the urine volume was 50 per cent less and the sodium concentration was 15 per cent under that of the opposite kidney, relief from hypertension was consistently improved by removal of that kidney. This pattern of disparity of renal function constitutes the so-called "Howard Test."

The pathologic physiology of Howard's empiric observation appears to be as follows: With narrowing of the renal artery, glomerular filtration is reduced in some or all of the nephrons. This reduction results in increased reabsorption of sodium and consequently a reduction in the excreted sodium but a less marked reduction is other solutes.

The measurement of separate kidney function is possible by the introduction of sufficiently large catheters into each ureter by cystoscopic manipulation. The following steps are taken.

VII. Preparation

1. All antihypertensive and diuretic drugs should be discontinued for seven days prior to the test.

2. Sufficient sodium (2-3 Gm. a day) should be included in the diet for four days prior to the

test to avoid difficulties in comparing the urine from the separate kidneys if there should be excessively low sodium concentration.

3. Fluids are withheld for 15 hours before the cystoscopy to permit a comparison of maximal urinary solute concentration before administering water.

4. Pentobarbital sodium is used for anesthesia.

Procedure

1. Large diameter (F8) multieyed catheters are inserted in each ureter.

2. A urethral catheter (F18) is inserted into the bladder after the cystoscope is withdrawn to afford a check on leakage about the ureteral catheters.

3. Indigo carmine is given intravenously, and if dye does not appear from the washings through the bladder catheter, but does appear from the ureteral catheters, the measurement of separate urine volumes from each kidney will be accurate.

4. Within 15 to 20 minutes satisfactory flow from the ureteral catheters is usually secured, and timed samples are then collected for basal urine volume (Uv), sodium excretion (UnaV), and total solute excretion (UosmV). Thereupon a priming dose of inulin (IN) and P-aminohippurate (PAH) is given, and a sustaining infusion of these substances in saline is maintained at the rate of 2 ml. per minute.

5. Urine and appropriately timed blood samples are collected in three periods totaling 30 to 60 minutes. Calculations of the glomerular filtration (G.F.R.), renal plasma flow (RPF) and maximal tubular excretory capacity PAH (TM-PAH) are made. Accounting is then made of the percentile contribution of sodium and its attendant anions to the total osmolarity of the urine, and the percentage of filtered load of sodium which is excreted in the urine (E.F.). Results are recorded in percentile differences in the two kidneys.

Interpretation of Data

Controls have been established upon patients without cardiovascular disease, and differences in renal function from the right and left kidneys are regarded as normal up to specific limits.[9] When these tests are applied to hypertensive patients, significant disparity between kidney functions is revealed in approximately one half of the patients with essential hypertension. These differences may be interpreted to indicate that (1) the hypertensive process involves the two kidneys unequally, or (2) unilateral renal disease is present. If there is no disparity of function, one may infer that each kidney is equally involved with disease. Likewise, renal disparities may exist, of course, without hypertension such as in unilateral pyelonephritis.

Failure to cure hypertension by nephrectomy or by vascular surgery has occurred even though unilateral reduction in renal dynamics was established prior to surgery. Probably the most likely explanation is that bilateral disease was present, or that pylonephritis in one kidney gave erroneous tests, or that the cause of hypertension was nonrenal in origin. If the renal blood flow measurements are low in both kidneys, clear evidence is given that bilateral disease is present.

The diagnostic value of comparative renal function tests may then be summarized.

1. Renal hemodynamics show variations between two kidneys in essential hypertension, in predominantly unilateral pyelonephritis, and in lesions of one or both renal artery systems.

2. In rare instances stenosis of the main renal artery or its branches may be present bilaterally, and the hemodynamics may be equal.

3. Decrease in sodium excretion is characteristically associated with stenosis of the renal artery, the most common cause of renal hypertension.

4. One major contribution in establishing bilateral renal disease is demonstrating that the function is decreased in both kidneys.

5. If the blood flow, filtration rate, and tubular excretory function are normal and equal in both kidneys, the cause for hypertension in practically all instances is not renal in origin.

6. Renal arterial lesions may exist and be responsible for hypertension, without giving marked disparity in sodium excretion. Patients with unilateral diminution in sodium excretion (positive "Howard Test") have had unilateral nephrectomy without curing hypertension.

VIII. Aortography

The visualization of the upper portion of the aorta and the renal arteries and their branches is usually necessary before surgery is considered. Furthermore, the radiograms must be of excellent quality to be informative and must illustrate in detail the caliber of the renal arteries. There has been considerable reluctance to subject patients to the premeditated risk of aortography for a considerable number of disastrous complications have been reported from translumbar aortography. McAfee[10] made a survey of 13,207

cases in which there were 37 deaths and 98 serious complications, including transverse myelitis, bleeding at the site of puncture, severe renal damage, fatal thrombosis, shock, and paraplegia. Others have reported slight morbidity and no serious complications on several hundred aortograms performed at their own clinics.[8,10-13] Transfemoral artery catheterization under fluoroscopic control, utilizing a pressure pump, and employing a rapid casset changer, has advantages which appeal to many, as compared to translumbar injection. If satisfactory films are obtained, diagnosis of arterial stenosis, regional or segmental ischemia, and renal aneurysm in one or both kidneys is possible. This information, coupled with the comparative renal function tests, permits formulation of preoperative plans indicating whether the surgery will probably be upon the vessels of one or both kidneys for revascularization, or more likely, will be a partial or complete nephrectomy. The ultimate decision is usually made in the operating room for pulse pressure recordings made proximal and distal to suspected stenotic lesions in the arteries may not substantiate the preoperative diagnosis of reduced poststenotic pulse pressure. Furthermore, the vascular lesions may be in smaller subdivisions of the renal vessels and not amenable to endarterectomy, resection of a local segment, or insertion of patch grafts, or by-pass procedures. Accordingly, operations on the kidney are carried out if evidence points to unilateral lesions.

Results

Smith[4] surveyed the literature in 1956 and collected reports on 575 patients on whom nephrectomy for hypertension was performed. Twenty-six per cent fulfilled the requirement that that blood pressure should not exceed 140/90 mm. Hg one year after operation. The cure rate might have been improved if all had been subjected to these diagnostic tests, and yet it is reasonable to expect that 35 to 40 per cent cures by nephrectomy is maximal expectation.

It would appear, from the early reports of bilateral renal revascularization, that the cure rate may be much higher, and some anticipate that 75 per cent or more of the patients will be normotensive two years or more following vascular surgery on the renal pedicle.[1,7,8,12,13]

A true appraisal of the results of surgery confined to the renal arteries will soon be possible, for a number of clinics are accumulating such information from patients upon whom these operations have been performed. There are skeptics who doubt that revascularization procedures will, indeed, produce such high cure rates and emphasize the need for strict and rigid criteria to evaluate the results of such surgery. They caution that transient periods of symptomatic improvement and/or partial lowering of blood pressure readings are consistent with observations upon hypertensive patients who have had any abdominal surgery. Smith's requirements, therefore, that the blood pressure should not exceed 140/90 mm. Hg one year after surgery should apply to arterial surgery as well as to nephrectomy to permit conclusions as to the value of surgery for the cure of hypertension.

Certain conclusions seem warranted as one views the hypertensive state in the year 1961. (1) The incidence of hypertension due to renal artery disease is much higher than was previously believed.[14] (2) The presence of renal artery disease can be diagnosed by angiography and separate renal function tests. (3) Surgical techniques still in the formative and exploratory stage give much promise of affording relief to a substantial percentage of patients for whom no other cure is known.

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65 East Sixty-Sixth Street.

Successful Postmortem Cesarean Section

Report of a Case

Curtis W. Cannon, M.D., West Palm Beach
Reginald H. Cooke, M.D.
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Jacksonville

The occasion to deliver an infant from a recently deceased mother is rare. When the situation presents itself, however, the delivery must be done immediately if one is to obtain a viable infant. Weil and Graber[1] reviewed the record of their hospital for the 10 year period of 1946 to 1955 and found nine cases in which undelivered mothers died during the third trimester of pregnancy. There were four cases in which delivery was not accomplished. In two of these, fetal death was evident hours before demise of the mother. In the two cases in which the fetus was alive at the time the mother died, the patients were not in the obstetrical division of their hospital. In one case delivery was accomplished vaginally, but the infant had no signs of life at delivery and was considered stillborn. In two of the four cases in which cesarean section was performed, the infant failed to survive. Kelly and Winston[2] reviewed the literature as to the cause of death of the mother in 111 cases of postmortem cesarean section with infant survival. In this series, eclampsia was the most common cause of maternal death and tuberculosis was the second most common. The medicolegal aspects of postmortem cesarean section have been discussed many times. Lattuada[3] and Whiteside[4] presented some convincing arguments for the necessity of performing postmortem cesarean section. In this regard, there is one statement in Lattuada's article which is of significance: "No individual has the right to deliberately and intentionally take the life of another or to deprive another of the right to live. The obligation to save human fetal life, when it can be done without destroying or jeopardizing another life, is absolute." To date, there have been approximately 116 successful postmortem cesarean sections reported in the literature.[5]

Report of Case

The patient was a 42 year old Negro woman, gravida VIII, Para VII, admitted at 3:34 a.m. on Feb. 14, 1960, with no history other than that she was pregnant. The blood pressure was 196/100 mm. Hg, the pulse rate was 64, and there was a trace of pretibial edema. She arrived on the obstetrical floor at approximately 4:00 a.m. and was noted to be semicomatose. It was assumed that on the way from the emergency room to the obstetrical suite she had had a convulsion which was evidenced by blood about the mouth and slight protrusion of the tongue. There was also fresh blood on the pillow next to the patient's mouth.

Examination, at this time, revealed the blood pressure to be 180/110 mm. Hg. Fetal heart tones were 140 in the left upper quadrant; the fundus was seven and one-half to eight months' size. The patient would respond to stimuli, but was incoherent. Deep tendon reflexes were hypoactive, and there was 1 to 2 plus pretibial edema. She was immediately given 10 cc. of 20 per cent magnesium sulfate in 1,000 cc. of 5 per cent glucose in distilled water at 30 drops per minute; this was started at 4:30 a.m., and at 5:00 a.m. the patient received 15 mg. of morphine and 120 mg. of Luminal Sodium. At 5:15 a.m., at the time a Foley catheter was inserted, the patient appeared to be well sedated, lying quietly in bed. She had stertorous breathing with audible rhonchi. Magnesium sulfate drip was running well. Urine obtained at this time was strongly positive for albumin. Other positive findings were blood pressure 160/110 mm. Hg, pulse rate 64, fetal heart tones 140 in the left upper quadrant, and respirations ranging between 18 and 26 per minute.

At 6:00 a.m. the patient had another convulsive seizure lasting five minutes. The blood pressure was 160/110 mm. Hg, respirations 23, pulse rate 54, and fetal heart tones 120. At 7:30 a.m. the blood pressure was recorded at 280/140 mm. Hg, pulse rate 56, respirations 26, and fetal heart tones 140. The physician was then called, and from the time the nurse called the physician to the time she went back to the patient's room she noted the onset of Cheyne-Stokes respiration. Artificial respirations were begun. When the doctor arrived, there were no palpable pulse, no blood pressure, and no respiration. Caffeine and sodium benzoate were given, with no effect.

Fetal heart tones could still be heard in the left upper quadrant, and a postmortem cesarean section was immediately performed. There was no evidence of bleeding from the mother on cutting the skin. A viable infant weighing 4 pounds 6 ounces was delivered from a vertex presentation, with an audible heart beat, but no evidence of respiration. The infant was suctioned and artificial respiration begun; oxygen and intravenous and intramuscular caffeine and sodium benzoate were also given to the infant. The mother was pronounced dead at 7:45 a.m. The infant continued to have a good heart beat, although respirations were slow; after prolonged artificial respiration including oxygen therapy, the infant began to breathe slowly on its own and was transferred to the nursery.

Further questioning of the husband revealed that the patient had never been seen in this hospital prior to this admission and that, on the day prior to admission, she had complained of a severe headache. The headache appeared to subside, and in the early morning, on the day of admission, he was awakened by her twitching, kicking, and foaming at the mouth. It was at this time that she was brought to the emergency room of this hospital.

From the Department of Obstetrics and Gynecology, Duval Medical Center, Jacksonville.

The infant was discharged from the hospital in good condition on the thirty-ninth day of life, weighing 5 pounds 4½ ounces, and at present is doing well.

Autopsy Findings.—Postmortem examination revealed the cause of death to be a cerebral hemorrhage resulting from rupture of the left anterior cerebral artery. Other findings included (a) mild hypostatic pneumonia, (b) moderately severe congestion of the spleen (280 Gm.), (c) slight congestion of the liver with microscopic findings consistent with those found in eclampsia, and (d) minimal myocardial hypertrophy.

Summary

A case of successful postmortem cesarean section is reported with a brief review of the literature. The favorable result of this rare obstetrical procedure is emphasized by the survival of this premature infant.

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Clinical Experience With Chlorpropamide

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Chlorpropamide is an arylsulfonylurea, closely related to tolbutamide. Although it is a sulfonamide, it has no bacteriostatic action. It is rapidly and evenly absorbed from the gastrointestinal tract, being detectable in the blood stream within one hour of ingestion and reaching a peak in two to four hours. It is slowly excreted unchanged in the urine, approximately 90 per cent being recovered in 96 hours. There is evidence to suggest that the drug is combined with protein in the blood, both globulin and albumin. Carbutamide and tolbutamide are not bound in this manner, and this difference may account for the more prolonged hypoglycemic action of chlorpropamide.

It has been said that the chief action of the sulfonylurea compounds is to stimulate increase in production of insulin and there is much to support this view. The beta cells of the islets of Langerhans in the pancreas are necessary for the hypoglycemic effect. Supporting evidence has been gleaned from various experiments. Totally depancreatized animals (or patients) fail to respond. If a dose of the drug, too small to induce hypoglycemia when injected into the femoral or portal vein, is infused into the pancreatic artery, a striking effect is noted in the increased output of insulin. The sulfonylureas also decrease hepatic gluconeogenesis without affecting the peripheral utilization of glucose. In hepatectomized and intact animals, the same hypoglycemic response will be obtained. Glucose utilization by peripheral tissues is increased, but to a far lesser extent than by insulin. Other factors, such as inhibition of glucocorticoid-induced hyperglycemia and an enhancement of hyperglycemic response to epinephrine in the diabetic, play vital roles.

Extensive study has been undertaken in chemical, pharmacological and clinical fields with reference to chlorpropamide. It has been found on repeated occasions that the diabetic requiring less than 40 units of insulin daily and whose disease started over the age of 40, is the most likely patient to be controlled with the drug. Various dosages have been tried in both the mild and the brittle diabetic. Lowenthal, Ross and Tully, investigating these problems in the same clinic in which we have been working, found that chlorpropamide was not effective in regulating the brittle diabetic, nor was its effectiveness increased by high dosages.

The purpose of this paper is to elucidate as far as possible the efficacy of chlorpropamide in a group of humble, often illiterate, indigent patients and to evaluate its safety.

Preparatory to this study, we surveyed 100 charts of patients taking chlorpropamide. Of

From the Diabetic Clinic, Duval Medical Center, Jacksonville, Joseph J. Lowenthal, M.D., Director.

This paper was awarded the prize from the Florida Diabetic Association for the best paper submitted by house physicians in the state of Florida.

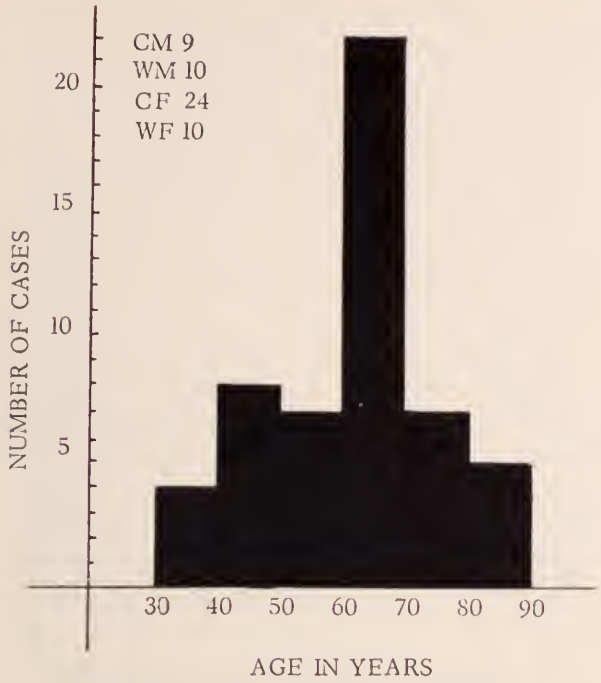


Fig. 1. — Age and Sex Incidence

these, 47 were rejected on grounds of the course of therapy being of less than six weeks' duration, failure of the patient to attend clinic for adequate follow-up, and loss of data for one reason or another. These rejections left a total of 53 cases for evaluation.

The only yardstick available for this evaluation was the fasting blood sugar. If the average fasting blood sugar was below 120 mg. per hundred milliliters, the control was considered good. On the other hand, if it was elevated consistently above this level, the control was termed poor. The others fell into the category designated "fair," the fasting blood sugar ranging from below 120 mg. at times up to 300 mg. occasionally. The majority, however, seldom showed more than 160 mg. The fasting blood sugar as an absolute index of control of diabetes is admittedly imperfect, but for reasons explained later this was the only objective method available in this study. No history of acidosis nor of profound hypoglycemia could be elicited in any patient.

There was a heavy preponderance of colored females, 24 out of 53. The remainder comprised 10 white males, 10 white females and nine colored males. Their ages ranged from 31 to 83, the majority falling in the 60-70 age group.

The cardinal triad of polydipsia, polyuria and weight loss was by no means the invariable initial complaint. The severity of these symptoms is largely unknown and therefore not considered in this article. In fact, only 20 exhibited this triad; 24 others were discovered to have diabetes incidentally, and the mode of onset in the remaining nine was unknown.

Twelve patients had received no specific therapy, apart from dietary measures in two, prior to a trial of chlorpropamide. Of the 38 patients on diet and insulin, there were 15 patients taking less than 20 units daily, and of these, 10 were well controlled and the remainder fairly well. Of those taking 20-40 units, 11 of 17 were well regulated, three fairly well, and three poorly so. The group taking more than 40 units of insulin was only three in number, with two having obtained fair control, and one, poor results on this regimen.

Only three patients were taking insulin of unknown quantity with apparently adequate response in two, but poor in the remaining one. Three patients received tolbutamide prior to

Table 1. — Review and Assessment of Therapy Prior to Chlorpropamide

Therapy Prior to Chlorpropamide	Number of Cases	Type of Control on Previous Therapy			
		Good	Fair	Poor	Not Known
No therapy	10			10	
Diet alone	2			2	
Diet and insulin	38	23	10	5	
15 — 20 units	15	10	5	0	
20 — 40 units	17	11	3	3	
Above 40 units	3	0	2	1	
Unknown amount	3				3
Diet and Orinase	3				3
Total	53	21	10	16	6

chlorpropamide, all being referred by private physicians, and in whom the degree of regulation was indefinite. These figures are listed in table 1.

Table 2. — Duration of Previous Therapy

Type of Therapy	Diet Only	Diet and Insulin	Diet and Orinase
Number of cases	2	38	3
Average duration of previous therapy	15 months	84 months	16 months

The duration of previous therapy ranged from one month to 21 years. The 38 patients on diet and insulin averaged seven years on that regimen. Two were adjusted on diet alone, and the remaining three on tolbutamide and diet averaged 15 and 16 months respectively.

Table 3. — Appraisal of Therapy With Chlorpropamide

Dose	250-500 mg.	
Length of therapy	2-24 months	Average 11.5 months
Results	Good	34 cases or 64%
	Fair	12 cases or 23%
	Poor	7 cases or 13%

The dose prescribed, both initial and maintenance, was 250 mg. to 500 mg., daily in a single dose, to be taken before breakfast. The length of therapy ranged from two to 24 months, the mean being 11.5 months. Good results were gained in 34 out of 53 cases (approximately 64 per cent), fair in 12 (approximately 23 per cent), but poor in the remaining cases (13 per cent). It is of interest that 25 patients lost an average of 9.5 pounds in weight while taking chlorpropamide and 19 gained an average of 7 pounds. In the remaining nine, the weight was static or uncharted.

Laboratory procedures to ascertain liver function were undergone by a limited number. In 10 patients subjected to a bromsulphalein test, seven obtained normal results and three showed more than 5 per cent retention after 45 minutes. In 12 patients, serum glutamic oxalacetic transaminase determinations were made and in all were normal, including those three with slightly abnormal bromsulphalein retention.

Toxic Manifestations

The incidence of toxic manifestations during treatment with chlorpropamide was commendably low. In only three cases were deleterious effects noted and all were confined to the skin; two were mild, and the third was severe. In this sole instance the patient concerned was a 49 year old colored woman, a member of the nursing staff, in whom diabetes had developed about five months prior to her introduction to chlorpropamide, and had been fairly well regulated on 30 units or less of NPH insulin. There was no previous history of allergy or drug intolerance. Chlorpropamide, 500 mg. daily, was prescribed and the regulation thereafter deemed excellent. Approximately six weeks later, a severe maculopapular rash developed over the entire body, associated with marked facial edema. Steroids and antihistamines were employed to good effect. She suffered desquamation and traces of the condition were evident after five months had elapsed.

Incidence of Complications and Diseases Associated With Diabetes Mellitus

Six out of the 53 patients had diabetic retinopathy; in 15 cataracts had developed, mostly bilaterally. Ten patients were in congestive heart failure, explained on the basis of arteriosclerotic heart disease; four had suffered cerebrovascular accidents with residual hemiparesis; and one had Kimmelstiel-Wilson disease. It was also noted that 15 had hypertension.

Discussion

This survey of 53 patients followed in an overcrowded outpatient clinic in a county hospital has shed considerable light on the practical problems involved in establishing adequate control of diabetes during therapy with chlorpropamide, besides giving a fair idea of the degree of success that could be expected in such a clinic.

As was mentioned earlier, the value of the fasting blood sugar as the sole index of diabetic control is inadequate, and in this clinic the two hour postprandial blood sugar was definitely impractical. Many patients were unable to obtain the correct foodstuffs as listed in their ADA diets, and many of those who were in a position financially to follow the diet were mentally and emotionally incapable of doing so, even after repeated instructions. On occasion, patients would appear for examination and fail to keep the succeeding clinic appointment. Ideal control of diabetes in this clinic's patients is therefore often difficult to obtain, regardless of the medication employed.

It was not an infrequent admission for the patient to say that he had not taken the medications "when he felt bad." Others would swallow an additional pill sporadically as "the first one made me feel better."

Once or twice the pharmacy stocks were depleted, necessitating a temporary return to insulin therapy for some or a lapse in the therapy. We think that these real, and mostly human, factors should be borne in mind during interpretation of the results. They may explain the inadequacy of control or frank failure to control the diabetes in some instances. Be this as it may, chlorpropamide has maintained good control in over 60 per cent of the cases, and fair control in over 20 per cent, bringing the total between 80 and 90 per cent. They were all mild diabetics, mostly over 50 years of age, taking 40 units or less of insulin daily, and without a history of acidosis.

Table 4. — Results

Drug Prescribed	Results (%)		
	Good	Fair	Poor
Insulin	63	26	11
Chlorpropamide	64	23	13

The last table depicts the degree of success using chlorpropamide in all 53 cases and while using insulin in 38 of these. The remarkable consistency of these figures is noteworthy. They indicate clearly that the measure of control of the same group is virtually identical whichever method is used. The ease of administration, however, of oral hypoglycemic agents is obvious, especially in those too old and too blind to inject their own insulin. Furthermore, while inquiring into the comparative regularity with which patients took their medications, one had the impression that more patients would swallow a pill more regularly than they would give themselves injections. There are no figures to illustrate this highly unreliable impression.

After a mean duration of therapy of almost one year, toxic manifestations were infrequent and apparently confined to the skin. Other reported adverse reactions were not encountered in this group, nor was hypoglycemia a problem in any patient.

Although three patients out of 10 subjected to a bromsulphalein test showed abnormal retention while taking chlorpropamide, they were without clinical evidence of hepatic disease. Since bromsulphalein tests were not carried out prior to the administration of the drug, it cannot necessarily be blamed for the abnormalities. Serum glutamic oxalacetic transaminase determinations were normal in all 12 patients tested.

Summary

Fifty-three diabetics taking chlorpropamide for an average length of 11.5 months have been surveyed. Good control of mild diabetes mellitus in patients beyond 50 years of age was obtained in 64 per cent of cases, and fair control in an additional 23 per cent.

In our hands the drug appeared to be safe for use in clinic patients. Ill effects were relatively few, 5.67 per cent in this series, which compares favorably with other reports on the use of chlorpropamide. Hypoglycemia presented no problem.

The paper serves to illustrate the practical difficulties encountered in adequate regulation of diabetes in an outpatient clinic composed of the indigent.

We are deeply indebted to Chas. Pfizer & Co., Inc., for supplying chlorpropamide and to Dr. John Beck for his invaluable assistance.

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VOLUME XLVIII
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Emphysematous Cholecystitis as a Postoperative Complication

A Case Report

E. H. SCHULTZ JR., M.D.
GAINESVILLE

Acute cholecystitis after unrelated surgical procedures is being recognized as a true complication of the fasting postoperative state. The production of gas in an inflamed gallbladder is an uncommon complication, but it is accompanied by a high incidence of necrosis and gangrene. In contrast to other diseases of the gallbladder, both conditions occur more commonly in males.

It is the purpose of this paper to report the first known case of acute emphysematous cholecystitis to occur as a postoperative complication.

Prior Literature

EMPHYSEMATOUS CHOLECYSTITIS.—Only 14 cases of emphysematous cholecystitis had been reported prior to 1945, but there are now approximately 70 reported cases in the world literature. Reports were recently tabulated by Edinburgh and Geffen.[1]

Signs and symptoms are essentially the same as in acute nongaseous cholecystitis. By x-ray examination gas may be detected in the lumen of the gallbladder within 24 hours, and in the gallbladder wall within 48 hours, of the onset of symptoms.[2] The importance of early diagnosis is emphasized by the presence of gangrene or necrosis of the gallbladder wall in three fourths of the cases in which the patient has undergone surgical treatment.[1]

Organisms of the Clostridium species are the most common finding on cultures in cases of emphysematous cholecystitis. Gas-forming coliform bacteria have been recovered less frequently. It is known that Clostridium welchii of apparently low virulence may be cultured from grossly normal human gallbladders,[3] and the presence of Clostridial organisms has been reported in 19 per cent of cholecystectomy specimens.[4]

Diabetes has been detected in about 25 per cent of patients with emphysematous cholecystitis. There is not the almost universal association seen between diabetes and gas-producing infections in the urinary tract.

The great majority of patients with emphysematous cholecystitis are over 50 years of age and have gallstones. The sex incidence, however, is surprising. Of 55 cases in which the sex was stated, 40 (73 per cent) of the patients were males. Furthermore, in eight reported cases of emphysematous cholecystitis which occurred in the absence of gallstones, seven patients were males.

The incidence of complications has been high, as would be expected. Pericholecystic abscess has occurred in over two thirds of reported cases.[1] Two instances of perforation with free pneumoperitoneum have been described.[5]

POSTOPERATIVE CHOLECYSTITIS. — Attention was first called to the unusual frequency of acute cholecystitis in the postoperative period by Glenn[6] in 1947. The tendency for acute cholecystitis to occur as a postoperative complication was reiterated subsequently by several authors, making a total of 75 reported cases.[7-10]

Acute cholecystitis has been reported following such unrelated operations as inguinal herniorrhaphy, cataract extraction, appendectomy, and transurethral prostatic resection. The factor common to all is a period of fasting, during which bile may concentrate and become viscid in the unstimulated gallbladder. The enforced supine position allows stones, if present, to gravitate from the fundus to the cystic duct. The use of narcotics further delays biliary drainage. When stimulated after several days by the first postoperative oral feeding, the distended gallbladder may be unable to empty itself of its thickened contents, and the functional or calculous obstruction furnishes the basis for acute inflammation in the gallbladder.[8] A temporal relation between the first postoperative feeding and the onset of postoperative cholecystitis has been regularly noted.[7,8,10]

From the Department of Radiology of the University of Florida College of Medicine, Gainesville.



Fig. 1.—Prior to partial gastrectomy, the gallbladder functions well and shows no abnormality.

Of 58 cases in which the sex was stated, the patients in 37 (65 per cent) were males. Although the presence of stones was not always determined, stones definitely were not present in 16 of 75 reported cases of postoperative cholecystitis. In this group 10 of the patients were males, and the sex was not stated in the other six cases.

Report of Case

A 71 year old retired man was admitted to the University of Florida Teaching Hospital with a chief complaint of difficulty in passing urine for three months.

Aside from symptoms of prostatism, the patient gave a history of having had a gastric ulcer nine years previously, demonstrated by x-ray examination, which responded promptly to diet. For one year there had been a recurrence of vague epigastric discomfort, aggravated by meals.



Fig. 2.—On the twelfth postoperative day, an anteroposterior view of the abdomen reveals the gallbladder to be greatly distended by gas in its lumen. A halo of gas about the lumen represents gas formation in the gallbladder wall and pericholecystic tissues.

On physical examination, the prostate was found to be firm but not enlarged. No other significant abnormality was detected.

Laboratory studies of the blood and urine revealed no abnormality. Fasting blood sugar was 98 mg. per hundred cubic centimeters. Serum electrolytes were within normal range. Acid phosphatase was normal. Gastric analysis showed no free acid. Radiologic examinations showed good concentration of contrast medium by the gallbladder, with no evidence of stones (fig. 1). The gallbladder contracted normally with fatty stimulus. Examination of the upper portion of the gastrointestinal tract with barium showed a small filling defect in the pyloric portion of the stomach, interpreted as probable early malignant disease.

A few days later, surgical exploration of the upper part of the abdomen revealed a 2 cm. mass on the posterior surface of the gastric pylorus. A subtotal gastrectomy and omentectomy were performed, followed by

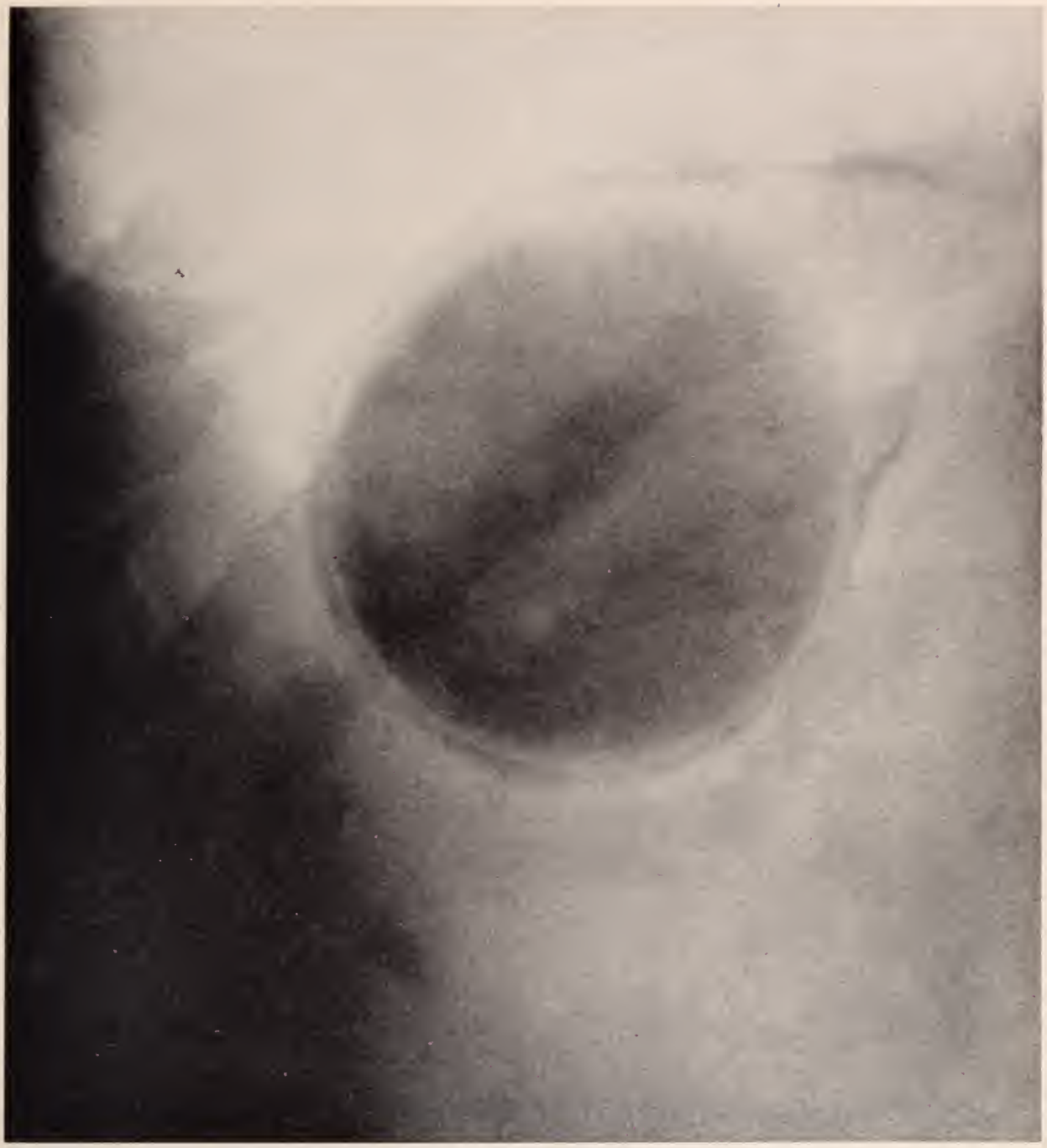


Fig. 3. — An enlarged view of the gallbladder area is illustrated.

a Billroth II anastomosis. The gallbladder was examined carefully at operation and was found to be grossly normal to inspection and palpation. Study of the surgical specimen revealed a small adenocarcinoma limited to the mucosa and submucosa, with no evidence of metastases.

After the operation the patient had some nausea, but remained afebrile. Meperidine was used sparingly for discomfort. Following the evening meal on the eleventh postoperative day, he experienced severe nausea and pain in the upper portion of the abdomen. During the night his temperature rose to 39.5 C. (103.1 F.), and the next morning the white blood cell count was 21,000 per cubic millimeter with a shift to the left. No clearly localizing signs were present; the possibility of pneumonia was considered.

X-ray studies were requested. Examination of the chest showed slight elevation of the right diaphragm and spotty atelectasis at the right lung base, consistent with a subdiaphragmatic inflammatory process. Examination of the abdomen showed a distended gallbladder with the lumen and wall outlined by gas, characteristic of emphysematous cholecystitis (figs. 2 and 3).

An operation was performed two hours later. The omentum had partially surrounded the gallbladder. The wall of the gallbladder was markedly injected and edematous. Upon incision of the gallbladder, foul-smelling gas escaped and about 100 cc. of dark bile was drained. A cholecystostomy was performed.

Culture of the gallbladder contents revealed Aerobacter aerogenes.

Aside from a wound infection, the postoperative course was uneventful. Drainage from the cholecystostomy rapidly diminished. No complaints referable to the upper portion of the abdomen were present six months later.

Discussion

There is no evidence that emphysematous cholecystitis is a distinct entity due to infection by gas-forming bacteria. It seems more likely that the condition represents secondary bacterial invasion and growth in an obstructed and inflamed gallbladder. Recognition of the condition allows a diagnosis of acute cholecystitis to be made from the plain x-ray examination of the abdomen, and further indicates that a severe and probably gangrenous inflammation is in progress.

The reason for the greater frequency of emphysematous cholecystitis in males is not known. The studies of gallbladder cultures for gas-forming organisms have not indicated whether the specimens were from male or female patients. Similarly, the higher incidence of postoperative cholecystitis in males is not understood.

In females, emphysematous cholecystitis and postoperative cholecystitis usually occur in the presence of underlying cholelithiasis and chronic inflammation. By contrast, either condition may occur in males in a previously apparently normal gallbladder.

Summary

Emphysematous cholecystitis and postoperative cholecystitis are relatively uncommon clinical manifestations of gallbladder disease, both conditions being more common in males.

A case of emphysematous cholecystitis occurring as a postoperative complication is reported.

Acknowledgement: Figures 2 and 3 previously appeared in a monthly diagnostic column of The New Physician, the Journal of the Student American Medical Association.

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EIGHTY-EIGHTH Annual Meeting

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Experience with Antidepressants in General Practice

Milton S. Goldman, M.D.
Miami Beach

Although their exact mode and site of action in psychiatric illness are still not definitely known,[1] the amine oxidase inhibitors now have an established role in the therapy of depression. Nevertheless, clinical investigations continue, one reason being that physicians wish to satisfy themselves as to the relative merits of the various members of this class of compounds and to compare them with respect to toxicity and side effects. There also exists the need for testing and comparing new chemical agents which, though not of this class, are recommended for the same symptoms.

In the course of many months, I have had the opportunity of serially observing the contributions made to psychotherapy by several psychotropic drugs. Early results obtained with Marplan,* an amine oxidase inhibitor, particularly in postmenopausel and milder cases of endogenous depression, were such as to suggest the desirability of a double blind study. While this method had to be abandoned because of the difficulty of maintaining accurate placebo/drug records in a busy office practice, it seemed useful to share our observations, especially in view of the fact that because of the original design all patients received the drug as unlabeled medication.

Material and Method

Marplan was administered to a random series of 65 private office patients, all females, with symptoms of depression classified as (1) endogenous (from mildly psychoneurotic to deep involutional) (2) three agitated depressive (3) reactive (4) postmenopausal involutional, and (5) manic-depressive in the depressed phase. Seven (four with endogenous and three postmenopausal symptoms) also complained of angina pectoris.

The patients' ages ranged from 26 to 69, with the great majority (52) falling in the 42-60 range. Many, as the diagnosis indicates, were going through or had just gone through the menopause. Aside from the latter, duration of the depressive symptoms was from one to two months to one or two years.

Therapy, depending upon both success and recency of initiation, varied from six weeks to seven months.

Dosage was uniform for the entire series: all patients were given 10 mg. three times a day the first week, reduced to 10 mg. twice a day in the morning and at bedtime, with a few changes in time of administration noted under side effects for the duration of therapy.

Routine blood counts and urinalyses were obtained on all patients. Liver function tests (transaminase, cephalin flocculation, cholesterol, cholesterol ester, protein albumin-globulin ratio and thymol turbidity) were performed biweekly on the first 12 patients for four weeks and then discontinued for reasons given later.

Evaluations of relative success or failure were made through personal observation and comparison of patient response to psychotherapy during Marplan treatment with that prior to treatment and under different chemotherapeutic regimens.

Results

Symptomatic.—The over-all evaluation (table 1) indicated an improvement in 60, or 92 per cent, of 65 patients. Even if only those listed as showing a good or excellent response are included (82 per cent), the positive value of Marplan in office practice is demonstrated.

The milder depressed psychoneurotic patients in the endogenous group responded as well as could possibly be desired, all 23 being judged "excellent." The depression of the seven considered "good" was of a more serious nature. All five under "fair" were in an involutional depressive state bordering on a psychotic melancholia. The only poor results in the endogenous category were in the three patients with agitated depression in which the agitation increased. This effect occurred at the very beginning of the study before it was

*Trademark for isocarboxazid, product of Hoffmann-La Roche Inc., Nutley, N. J.

Table 1.—Evaluation of Results of Administration of Marplan to 65 Female Patients with Symptoms of Depression

Depression	Number of Cases	Results			
		Excellent	Good	Fair	Poor
Endogenous	38	23	7	5*	3**
Postmenopausal involutional	21	3	17		1
Reactive	4	1	1	1	1
Manic—depressive, depressed	2		1	1	1
Totals	65	27	26	7	5
		82%			
		92%			

*Involutional bordering on a psychotic melancholia.
**Agitated.

realized that these patients were not suited to this type of therapy.

The four patients with reactive depression responded to Marplan according to the severity of the depression, one each being judged excellent, good, fair and poor.

The drug acted favorably on the depression of the two manic-depressive patients; response in one was good, in the other, fair because of a side effect discussed later.

Of the 21 cases of postmenopausal depression, the results in three were excellent and in 17 good. There was only one failure, which is described under the discussion of side effects.

Three of the postmenopausal patients also had angina pectoris, which was about 75 per cent relieved. In addition, but not a part of this series, four men, depressed and apprehensive, who had anginal type chest pains for which no organic cardiac lesion could be demonstrated, were all improved by Marplan and in three considerable relief occurred.

LABORATORY.—Throughout the study, blood counts and urinalyses were normal, there was no noticeable tendency to increased appetite or gain in weight, and blood pressure remained within normal limits.

Although the amine oxidase inhibitors have been reported to be potentially deleterious to the liver,[2,3] there was no evidence of harmful effect with Marplan, either laboratory or clinical, in this series. There was no change of any appreciable nature in any of the findings of the several liver function tests performed every two weeks on the first 12 patients, and these laboratory studies were then discontinued as an unnecessary routine measure. All patients, however, who complained of any side effects were tested at the time of complaint, and here again there were no variations from the norm.

SIDE EFFECTS.—The only side effects noted or reported were, with three exceptions, transient and mild: (1) nausea (five mild, two severe), (2) anorexia (three mild) and (3) insomnia (eight mild, one severe).

The insomnia was overcome by adjusting the time of the second daily dose from bedtime to midafternoon, and in some cases adding a mild sedative at bedtime.

Medication was discontinued in three cases because of side effects, two involving nausea. In one instance the nausea did not appear to be severe, but cooperation was poor and the patient refused to continue the drug. One postmenopausal patient complained of "peculiar sensations, giddiness, weakness and synocopal attacks," and discontinuance was considered expedient because of her apprehension about "new" drugs.

Discussion

There are certain aspects of the present study that are not strictly part of the "results," but seem sufficiently important to merit discussion.

It is of course possible that by increasing the dosage in the relatively intractable patients, as found by Kimbell and Pokorny[4] and Darling[5] among others, greater improvement would have occurred, that is, some might have been "excellent" instead of "good" or "good" instead of "fair." This was not done because it was the intention to observe the drug's effect under uniform schedules, and because of the possibility of unwanted side effects on higher dosages than regularly recommended in office patients.[6]

Results in the two manic-depressive patients were actually good, but the development of nausea in one, which could not be overcome at the effective dosage of 20 mg. daily, made it necessary to term the response only fair. These same patients had been treated previously with Marsilid* while in a depressed phase, and comparatively the results with Marplan were so impressive that not only would there be no hesitation in using it in other manic-depressive patients, but the dosage would be definitely increased in view of the lack of toxic effects in the present series.

As also found by others, the use of Marplan alone (or apparently any similar compound) does not seem to be the drug of choice in agitated depressive patients, all three in this study responding with increased agitation. The fact that these three are now doing well on Librium,** a calming and

*Iproniazid, Hoffmann-La Roche, Inc., Nutley, N. J.
**Trademark for chlordiazepoxide, product of Hoffmann-La Roche, Inc., Nutley, N. J.

relaxing agent, is further evidence that no single drug can be relied upon in different psychiatric conditions.

In postmenopausal cases, the depression is usually mild and accompanied by anxiety neurotic states with extreme apprehension, insecurity feelings and undue fatigability. Organic disease has been found to be of minor importance as compared to the complaint; the main problem in these postmenopausal involution depressions is that the patients "can't face the day" and become irritated and introspective. Here Marplan, presumably by "energizing" the patients psychically and reducing their fatigue, produced especially satisfactory results.

A final impression of the antidepressants that may be important, though perhaps a truism, was obtained by observing certain individual responses to different drugs. For example, good results were obtained with Tofrānil* in three patients who failed to respond to Marplan, while three others responded well to Marplan after Tofrānil had been used to no effect. In other words, there seems to be no one best drug in any given indication, including depression, for all patients. In general, my experience shows that Marplan was more consistently effective than two other drugs in the same general category of amine oxidase inhibitors and in treating depression it is my drug of choice, with Tofrānil, not an amine oxidase inhibitor, second choice.

Finally, since the formal conclusion of this study I have started adjusting maintenance dosages downward from 10 mg. twice a day to once daily, giving Marplan in the morning after breakfast to patients already stabilized. This amount seems to be satisfactory, sufficient to maintain the patients in a comfortable and happy mood.

*Geigy Pharmaceuticals, Ardsley, N. Y.

Summary and Conclusions

On administering Marplan, an amine oxidase inhibitor, on a uniform dosage schedule of 30 mg. daily initially and 20 mg. daily as maintenance, good to excellent results were obtained in 53 (82 per cent) and fair to excellent in 60 (92 per cent) of 65 patients with endogenous, postmenopausal involutional and reactive depression, including two manic-depressive patients, in depressed phase.

The only failures in the endogenous group of 38 were in three patients with agitated depression, in whom the agitation increased.

The response in 20 of 21 patients with postmenopausal depression was good to excellent; in one the drug was discontinued because of reported side effects.

Three patients with angina and four with anginal type chest pains experienced a reduction in the angina of at least 75 per cent.

Side effects noted or reported were with three exceptions transient and mild, consisting of nausea, anorexia and insomnia.

Blood counts, urinalyses and blood pressure remained within normal limits, and there was no noticeable tendency to increased appetite or gain in weight.

Several liver function tests performed biweekly on the first 12 patients and thereafter on all patients who exhibited side effects showed no changes of any appreciable nature.

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President's Page

AMPAC

If each member of the medical profession could have been present at the Clinical Meeting of the American Medical Association in Denver on November 26-30, 1961, there would not be much use for me to write this page. This was a remarkable meeting. Throughout the whole meeting there seemed to be a serious deep-seated realization that American medicine was facing a challenge—"the chips were down"—during the next twelve months and the years to come such as it has never faced before.

There was no evidence of defeatism, equivocation or the slightest idea of giving up the fight against socialized medicine. For the first time I saw evidence of AMPAC (American Medical Political Action Committee) and the dedication that these men had to bring it into a full workable realization. It is not in the scope of this page to define AMPAC and all its ramifications. I think it is understood that it is a voluntary, nonpartisan, nonprofit, unincorporated group whose membership consists of physicians, their wives and any others who are interested in free enterprise and especially against socialized medicine in any form.

For years doctors have been told to stay out of the affairs of government. Our political "friends" have assured us that they had the situation under control and all they asked of us was to care for the sick and they would see that everything else was taken care of. This they have almost done to the detriment of the doctors and their patients.

It became evident, therefore, that such an organization as AMPAC would have to be formed to combat our opposition. This was chiefly for two reasons: first, to educate not only the doctors but all members of AMPAC and help them to understand thoroughly the political issues involved, and second, to organize them as an effective political action group. For too long medicine and its friends have been pushed around under the guise that any political action on our part was "bad medicine." We are not alone in this fight and we are not going to lose this fight if we will present a solid front along with our allies and do what is the right thing not only for medicine but for freedom. Doctors have every right to take part in every civic undertaking whether it be a minor office or the highest in our land.

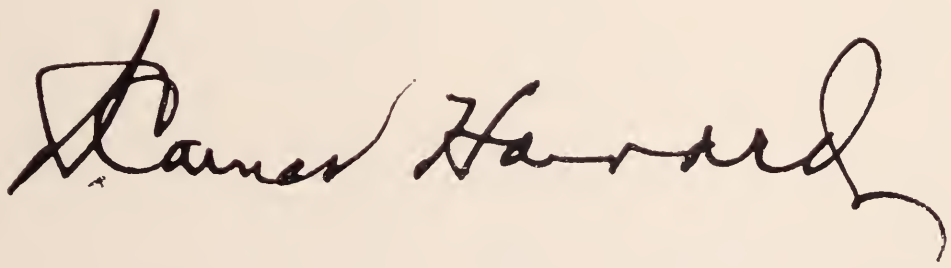
AMPAC as a nationwide organization should be the answer to many of our problems. In no way does it take the place of committees such as the one we have in Florida known as the Florida Medical Committee for Better Government. It should be clearly understood that it supplements but does not supplant in any way. It is to help wherever help is needed. Here as elsewhere in our fight against socialized medicine we must have unity.

As I mentioned, doctors have as much right morally to express their opinion on political matters and fight for them as any other segment of the population. When it comes to such political matters as the King-Anderson bill, we not only have this right to express our opinion, but since it involves the health of our patients and therefore of medicine, we are obligated to point out the pitfalls in such legislation. This bill is something which is insidious, and once it becomes a law, our birthright as doctors is gone.

In the past few years the average life span in America has increased to 70 years. This increase in life span has been due to research, doctors and the will of God Almighty. A few years back, before the life span was increased, there were only a very few between the ages of 65 and 70. Now this number has increased into the millions and each one has a vote. How much of this furor about the health of the individual is concerned about this or is it concerned about their vote? It is rather ironical that these people whose life span we have been to some degree instrumental in prolonging are the ones we have to convince not to vote for the King-Anderson bill.

Each year that goes by finds the problem of care for the needy aged sick and the near needy aged sick being better and better cared for. These two groups are the ones which the Kerr-Mills bill will eventually take care of. Each day that passes sees more implementation of the Kerr-Mills bill. THERE IS NO PROVISION IN THE KING-ANDERSON BILL FOR THE NEEDY AGED SICK OR THE NEAR NEEDY AGED SICK IN ANY WAY.

Doctors, you are now, whether you realize it or not, leaders of your country, which is recognized as the greatest in the world. There were five doctors who signed the Declaration of Independence. The defeat of the King-Anderson bill is our Declaration of Independence. Do everything in your power for yourselves, for your patients and for all free men of the future.





Editorials

Successful Postmortem Cesarean Section

The case report on successful postmortem cesarean sections by Drs. Cannon, Cooke, and McDowell appearing in this issue of The Journal is very interesting and well presented. The references given represent a good summary of the literature on this subject. The obstetrician would do well to familiarize himself with good, acceptable treatment of the dying patient with a viable fetus. This is especially true in cases of sudden death, such as cardiac arrest, when the plan of treatment should already be established in the physician's mind.

Weil and Graber[1] in their report in 1957 gave these conclusions:

"1. Any gestation past 28 weeks has produced a potential independent human life and in case of death of its host it should be given every possible chance of survival.

"2. 20 minutes is usual limits of life in uterus after mother's death.

"3. If positive signs of fetal life were present shortly before the death of the mother, we must assume the fetus to be alive and immediately deliver the baby even with absent fetal heart tones.

"4. Legally, we are not justified in delaying for the purpose of obtaining operative permits."

There are some additional questions in my mind concerning this procedure which I would like to discuss. If at all possible, I think it is advisable to get the husband's consent if time will permit, but the section should not be delayed if this is not available. If permission is refused by the husband, what then is the proper approach? Lattuada[2] advised to proceed with the section, even if the husband has denied his consent, and pointed out that the surgeon would be legally protected. I am not so sure that many of us would be in favor of proceeding with the section against the husband's wishes.

I would also like to emphasize the necessity of prompt action if a postmortem section is to be performed. The procedure should be carried out as soon after death as possible, the sooner the better.

There is, in addition, the question of how to determine that a patient is dead in a short period of time, without running the risk of error. I have seen premature babies sent back from the morgue and judged to be alive. I have also seen one adult come back from the funeral home after a stay of several hours, and the only way one could tell that this patient was alive was by running an electrocardiogram. It seems to me that our greatest legal pitfall could be in performing a postmortem section on a patient thought to be dead, who might dramatically make a recovery. I can visualize such a case as acute cardiac arrest which might respond to external massage or open massage. Should the doctor spend his time doing the cardiac massage and when should he stop this and proceed with the postmortem section? This could definitely present a problem.

If the case happens to be a medical problem with material death that can be anticipated, I think it would be well to plan to have adequate consultation to determine the exact time of maternal death. If the procedure should be so unfortunate as to provoke future legal action, this consultation might prove to be very valuable.

I have had the opportunity of performing one successful postmortem section, not reported in the literature, during my residency. When I rushed down to tell the father that we had saved the baby, but also had to inform him of the unexpected death of his wife, his comment was, "But, Doctor, what am I going to do with the other nine at home without a mother?"

This case report is excellent and very thought-provoking. We should anticipate maternal death in the critically ill patient, regardless of the service in the hospital. I certainly recommend postmortem sections performed at the proper time and for the proper indications.

1. Weil, A. M., and Graber, V. R.: Management of Near-Term Pregnant Patient Who Dies Undelivered, Am. J. Obst. & Gynec. 73:754-758 (Apr.) 1957.
2. Lattuada, H. P.: Postmortem Cesarean Section; Surgical and Legal Aspects, Am. J. Surg. 84:212-214 (Aug.) 1952.

T. Bert Fletcher Jr., M.D.
TALLAHASSEE

Do It Yourself Diplomacy

It has been my lot to travel, and some of the traveling has been voluntary. Hitchhiking Europe from Norway to North Africa, from London to Vienna was in quest of further knowledge in a specialty. Probing behind the Iron Curtain to Moscow and Leningrad was an attempt to differentiate propaganda and reality. Service in the United States Armed Forces during World War II and the Korean conflict was responsible for many of us more than circling the globe. In recent years there has been an opportunity for work in various areas through the Caribbean from Antigua to British Guiana. The more one sees of people the more one is conscious of the paradox that people are quite alike and yet quite different.

"All men are created equal"—that is, conceived by sperm fertilization of egg and delivered on the end of a placental cord. A row of cribs at any baby show impresses one with the similarity of humanity. Yet at the time of conception endowment by heredity has varied and, from that moment on, environment and chance take a hand. Thus newborn cries may sound alike but not their volume or their quality, and the air inhaled will vary from the humidity of Houston to the dust of Damascus.

Man may differ in size, ability, color, creed and motivation, but each individual possesses all of these to some degree and how he chooses to use, ignore, develop or exploit them depends on him. It would seem that there is enough in common among men for understanding of one another. The difficulty lies in our tendency to demand from other men our standards, expect them to fight under our rules and to seek in life what we desire. If standards, rules and goals vary among Floridians, imagine the divergence throughout the world.

For instance, it is inconceivable to us that given a choice there are men who will take tyranny over freedom, war over peace. Yet the assets of freedom and peace are vague to one who is starving and without hope of relief. One has only to wander the back streets of Cairo, Calcutta or Macao and look upon the dilated veins bulging under the slack skin of emaciated bodies, the bloated bellies of marasmic babies to understand any lack of perception into the glories of freedom.

Yet most men who have known freedom will risk their lives to regain it and resent forever having had it threatened. Talk with a Dutch farmer on the German border, listen to a Russian describe the cannibalism during the Nazi 900 day siege of Leningrad, ask a Hungarian freedom fighter about the Soviet tanks in the streets of Budapest. Determination for freedom was responsible for the birth of America, and evidence of this same spark is seen today in the avalanche breaking through the Iron Curtain into West Germany, through the Bamboo Curtain into Hong Kong, through Castro's Coconut Curtain into Miami.

A great portion of the world is envious of the success of our American free enterprise system. Dollars bring a glint in the eye of a merchant of Venice, a pickpocket of Paris, a peddler in the Casbah of Algiers, a fig picker at oasis Bousada in the Sahara Desert, even the semicomatose in an opium den in Bangkok. A Korean papasan and head of a village working in his rice paddies for a year might earn eighty dollars. An attractive girl of the same village during occupation of American troops could net the same amount in a week. Imagine the effect of the dollar on the economy of this village, the resentment among the native men and for that matter the men in the Allied occupational forces with less dollars. Remember the average Russian laborer's earnings approximate the compensation wages of our unemployed. This alone is enough to incite Khrushchev to throw a shoe at the United Nations.

Yet envy by others is no cause for our apologies or reason for bewilderment at our lack of international popularity. Top position is a lonely role and a fair target. It takes more continued strength, skill and alertness to remain on top than was ever required initially to get there. A fat champion is soon dethroned, but a worthy and conditioned one welcomes every opportunity to stand up to both subversive and direct attack.

There is no question but that we have a happy and exciting way of life that is succeeding remarkably for us and can serve well for others. It has proved its worth in West Germany and Japan even after unconditional surrender. Compare the spirit and vitality of the people of thriving Düsseldorf or Hamburg to the man in the street of sullen old Moscow as he gazes dully across the tremendous gap that separates him from the Kremlin's spouting Niks and sputniks.

Our ultimate goal is to stimulate all men to work for peace and a standard of living that is equal to their highest potential in a *free* society. Where we tend to fail is in our naive method of promoting this international Utopia. To force freedom and decree progress on an unprepared people brings collapse and chaos as the only props they possess are torn from them. Progress in freedom cannot be given; it must be earned. The gifts of patronizing handouts stir resentment in many, encourage begging and blackmail from others while perpetrating a gradual blood-letting type of national suicide for us. The techniques of successful production, however, can and must be taught. Far sounder it is to lend specialists and advanced students to help underdeveloped countries help themselves. The cooperation of mutual achievement wins converts, maintains respect, strengthens friendships while also raising standards.

Our State Department is making an effort along this line and must necessarily promote, direct and carry out the major portion of this effort. Yet, as in all progress, individual initiative can be used to spark vitality and ingenuity, cut red tape and reduce waste in expense by increasing energy expended. American specialists whether farmers or pharmacists, doctors or engineers, bankers, brokers or industrialists, when traveling abroad, should make the extra effort to contact the local foreign men in their specialty. There is no better way to enjoy a country for similar interests rapidly reduce barriers and cooperative attack on specific problems may speed solutions. When shown a way out of a dilemma, man spends his energy getting himself clear rather than envying those who are already out. There is an added dividend. Not only does the act of teaching organize and crystallize thought so that we better understand ourselves but those who are teachers often find themselves students. No man is so advanced he cannot learn from another. Although ability to speak the other man's language must never be discounted, language today for us affords less difficulty as English is becoming, if not the primary, at least the secondary language of many countries.

The peninsula of Florida is the springboard to the Caribbean and South America and the logical headquarters for promotion of Inter-American goodwill. Doctors particularly will enjoy taking an active part in this program. The opportunity of facing a variety of new problems presents a challenge that shakes us out of our everyday routine into a healthy, vigorous pioneer activity. When planning a trip write the public relations office of the United States Consulate and of the local government for contacts in your specialty. Attend local medical meetings and inquire into the particular problems. American medical societies meeting in foreign cities should encourage local attendance and seek from them invitations to their hospitals and clinics. Once contact has been made, return visits may be arranged on a personal basis or through government sponsorship. More foreign doctors should be urged to visit America to evaluate our approach to similar problems. An attempt for even better liaison is planned in Jamaica. A voluntary Inter-American agency to work in conjunction with United States agencies is to be formed. Its function will be to coordinate data so that visiting specialists, who are willing to contribute their services, can be utilized with utmost efficiency and still leave enough time for sun, rum, calypso or whatever.

D. RALPH MILLARD JR., M.D.
MIAMI

Editor's Note: This editorial was solicited from Dr. Millard. His contacts with our Caribbean neighbors as Honorary Consultant in Plastic Surgery to the governments of Jamaica and the Bahamas necessitates regular visits and active surgical participation in each area, permitting a current evaluation of our neighbors' problems.

A Way of Life

Dr. William Osler, addressing the Yale students on April 20, 1913, with methodical precision advocated firmness to his definition of "A Way of Life:" a wholesome body, a trained mind, a purpose to every day's activity, the practice of living for the day only and for the day's work, and a time to think and to reflect. He stated, "The quiet life in day-tight compartments will help you to bear your own and others' burdens with a light heart." A way of life for physicians would be ideal if set forth in firm principles and followed daily. To arrive at a definite conclusion would be fruitful if tempered by many angles of activities.

The pattern which eventually becomes a way of life has its beginning when the physician begins his first practice. He should strive to build it as fast as possible keeping in mind at all times that availability, not only to his patients but to all those who would seek his help, is more than

75 per cent of the battle. When the pattern of his practice is established, there should come a list of "musts" as the necessary ingredients of concrete firmness to a purpose in life: term insurance to protect the physician's family in the event of his premature death; the purchase of a home with a long term mortgage, if feasible; and the maintenance of office expenses at a minimum.

As his practice is established and children are born, the physician should augment his term insurance and begin an educational fund for each child with a savings account, purchase of mutual funds, insurance or a combination of any of these. Ample health-accident insurance should be purchased and a retirement fund begun; it may be only a small amount put away in some type of security—stocks, bonds or mutual funds. When income permits, the purchase of income-producing property is a tremendous step along the path of security.

In the pattern as it becomes a way of life, good health and a capable earning capacity are assumed. The physician, adding to the enjoyment he derives from the practice of his profession, will plan vacations at intervals, a careful budget for the home and time to spend with his family.

The pattern for a way of life does not work out smoothly; there will be sacrifices before the end results are achieved, and each case is individualized. The material aspects are only points of interest, and the physician, himself, must provide the color to break the monotony between these points. A happy family, a satisfying social life, his all-important religious life, and attitudes of thankfulness, humbleness and graciousness are the wellsprings.

A Way of Life is what every physician wants; yet it is simply what he makes out of life. The formula is easy to understand: Let each day have a purpose, a full day of meaning, a day in which one is wanted and is necessary for something or someone.

Jack L. Cantor, M.D.
Miami Beach

Discipline

Having a dog with a diploma from the K-9 Obedience School sounds impressive—for the dog. It is in reality an impressive and desirable lesson for the owner.

Several months ago, in the hope of gaining some control over a wire-haired terrier puppy, my son and I blithely enrolled him—and, as we found later, ourselves—in a beginners' class. This step was taken with the hope that *they* would in the end return a dog ready to take his place among the good dogs in the neighborhood.

Upon the first night of class, a class taught by a group of dedicated, intelligent, understanding dog lovers, we found the process of education involved us, as owners, as well as Pete, the dog. In later weeks, by constant repetition of properly conceived and executed commands, the three of us were made to respect each other and from that mutual respect came control of the dog; and more important, control of ourselves—in that we asked only the reasonable from the animal, gave our commands in a firm standardized manner understood by the dog, and evolved a mutual understanding of the commands and the method of discipline to be used when a command was improperly given or carried out.

Pete now has his diploma, and with his training is a better dog of the neighborhood. My son and I now understand a little better that on a neighborhood, community or national level self discipline, properly planned and constant in direction, will make each of us a better member of society. The three of us now enjoy each other more because of this understanding.

A physician is human in his reactions. The human reaction is to take a problem to the proper authority to be solved for us. In most instances, we do not participate in this solution; yet we frequently are critical of the solution—be it from organized medicine or the many levels of authority in our democracy. From participation comes an opportunity to understand better each problem and to develop a discipline which will aid in answering our many critical questions concerning all levels of personal and public relations.

There is much to be learned at K-9 Obedience School.

T.M.



Aids to Practice

Question: What's this about a "taxpayer account number?"

Answer: Your "taxpayer account number" will be required on certain tax returns and documents beginning in 1962, such as your Declaration of Estimated Tax for 1962. Your social security account number will be your taxpayer account number, if you have ever had one. If you file your Declaration without showing a social security account number, you will receive a letter and a form by which to apply for a number. If you are involved with a partnership or professional corporation, the taxpayer account number applicable to returns for these entities will be their "employer identification number." A $5.00 penalty applies.

Question: Will more doctors' returns be audited when the Internal Revenue Service hires the new agents recently authorized?

Answer: With a larger staff available to investigate returns, undoubtedly physicians will receive their share in the increased coverage. Helping, too, will be the new electronic machines which, among other things, will compare the income a taxpayer reports on his returns with payments others report they made to him. There is no indication, however, that the profession has been singled out for special treatment, or that new criteria will enter into the selection of a doctor's return for audit.

Acknowledgment: In the November 1961 issue of The Journal of the Florida Medical Association this section carried reference to continuous form statements naming the Debisteve Company, Minneapolis, as the only practical source of such forms for the physician known to the panel, and asking for information on other competitive sources. A Pompano Beach physician kindly sent The Journal materials from the Medical Arts Press, 2908 Emerson Avenue South, Minneapolis 8, which apparently were identical to those of the other Minneapolis firm. This may represent a new source or a new name for the old.

Question: What office (business) machines do you recommend for the efficient operation of the average medical office?

Answer: Every medical office, in our opinion, should have a top quality typewriter and an adding machine. Whether they should be electric machines or not would depend upon the volume of activity on each and the capability of the aides who use them. For instance, the extra cost of an electric typewriter would be wasted on the poor typist who uses the machine for a combined time of an hour or two a day. But the assistant who can utilize the inherent speed and operating ease of a fine electric typewriter, and who must work regularly as much as half of her time on histories, reports, correspondence and forms, can many times over pay the additional cost of the electric typewriter. A small manual adding machine is sufficient for most offices; the partnership or clinic utilizing a full time bookkeeper should equip her with an electric machine. Other machines can more than pay their own way, depending upon the nature of the practice. A copy machine can be most helpful to reduce the need for typing out information already of record. The dictation machine has largely replaced or has supplemented the shorthand writer. A postage meter, while it may not be justified in terms of time, can control the accountability for the postage expense of the office. A check writer adds to the time element rather than reducing it, but may be worth while for the "insurance" it represents. A billing machine can speed the load and increase accuracy for the large partnership or clinic which has sufficient volume to utilize it, but in this connection, the selection of the machine is critical. Be sure the machine is adaptable to your needs rather than vice versa, and that you do not buy a "Cadillac" to do the job of a bicycle.

Editor's Note: Questions and comments on appropriate economic and practice management problems are invited for publication in this column. Answers to your questions will be provided by a panel composed of various Florida members of the Medical-Dental-Hospital Bureaus of America.



Clinical Comment

A Symposium on Clinical Medicine and Surgery

The Duval County Medical Society and the University of Florida College of Medicine presented a symposium of interest in many fields of medicine and surgery on Nov. 12, 1961. The symposium was sponsored by Lederle Laboratories for Northeast Florida. The morning session's moderator was Capt. Robert O. Canada, commanding officer of the United States Naval Hospital in Jacksonville. Dr. Samuel P. Martin, chairman of the Department of Medicine of the College of Medicine, presided over the afternoon meeting.

Dr. Steven O. Schwartz, Professor of Medicine at Cook County Postgraduate Medical School and Director of the Hektoen Institute of Medical Research in Chicago, was the first speaker for the morning session. Dr. Schwartz presented a series of slides which pointed out the importance of observation in diagnosis. A few of the salient points made by him follow:

The Gums. Uncomplicated hypertrophy often indicates Dilantin intoxication. Hypertrophy plus massive bleeding is a manifestation of scurvy. Both of these plus infection imply acute leukemic states. All of these plus an agranulocytic membrane are manifestations of acute monoblastic leukemia. In acute monoblastic leukemia diffuse skin infiltration and hemorrhages are also seen.

The Tongue. A smooth tongue is characteristic of pernicious anemia. This is also seen in vitamin and iron deficiency. The "beefy" red tongue often erroneously associated with pernicious anemia is due to a concurrent vitamin B deficiency. Slides illustrating monilia infection of the tongue and macroglossia were also shown. Macroglossia may be the only manifestation of primary amyloidosis.

The round faces of Cushing's disease, the superior mediastinal syndromes and the Mikulicz syndrome (most often an indication of the lymphomas) were differentiated. Remarkably illustrative slides of Plummer's syndrome, myxedema, polycythemia, both primary and secondary, scleroderma, sarcoidosis, and the tower skull of congenital hemolytic anemia were used for discussion of differential diagnosis.

The second speaker of the morning was Dr. Thomas M. Durant, Professor and Head of the Department of Medicine at Temple University School of Medicine in Philadelphia. The professor talked on the management of resistant cardiac failure. Much of his talk appears as the lead article in the month's edition of the Medical Clinics of North America (Vol. 45, No. 6). Certain pertinent points emphasized by Dr. Durant and not appearing in this article bear repeating.

The importance of treating the patient and not just heart disease was stressed. As the problem of cardiac failure becomes more complex, an understanding of the associated altered physiology and endocrinology becomes increasingly important, and it is just such understanding on the part of the physician that makes for a longer life for the cardiac patient. The physician is called upon from time to time to make a critical estimate of the situation, and such a critique must not exclude the doctor himself and his previous decisions.

The misuse of the now popular thiazide oral diuretics was pointed out. Although they are effective when the chlorides are too low for the faster mercurial diuretics to be efficacious, they have the serious disadvantage of depleting potassium, elevating uric acid, interfering with the intermediary metabolism of glucose and poor absorption by the edematous intestine. Proper supplemental potassium therapy is highly important, and the added use of spironolactone becomes important as dilutional hyponatremia becomes an important factor. Adrenal cortical hormones may prove of great help in the advanced case of cardiac failure, where, apparently, there is a dissociated

adrenal function. Here the adrenal is able to produce aldosterone, but the 17-ketogenic steroids are increased. There is an impaired response to water load and an increase in insulin sensitivity is demonstrable. Dr. Durant also pointed out the importance of converting arrhythmias, the early recognition and treatment for almost imperceptible thromboembolism and the possible use of radioactive iodine and propitiously timed venesection in the treatment of what was previously termed intractable failure.

Dr. Martin M. Hoffman, a practicing internist in Montreal, Canada, was the final speaker of the morning. His well organized and well delivered discussion of adrenal physiology and its clinical implications was approached from three major facets: (1) the maintenance of homeostasis, (2) the genesis of disease, and (3) the pharmacological activity in treatment. The clinical implications of each of these were stressed. The importance of understanding the servomechanism of the adrenal-pituitary axis was noted particularly in that a delay period of approximately four hours is required for maximal adrenal response to ACTH. This maximal response produces approximately 10 mg. of hydrocortisone per hour. Time and amount may be important clinically, for instance, in acute thyroid storm or an exacerbation of systemic lupus erythematosus. Furthermore, if more than 50 mg. of cortisone is given, ACTH is suppressed within 24 hours and only one tenth of the normal cortisone is produced. Thus the need for larger doses of these hormones in periods of unusual stress is apparent.

Clinical suspicion was held in high regard by the speaker in all forms of the diseased gland. As examples he pointed out the clinical manifestations of primary aldosteronism due to its electrolytic effects, namely, polyuria, polydipsia, nocturia, poor urinary concentrating ability uninfluenced by Pitressin and the hypokalemic alkalotic production of paresthesia, tetany and muscle weakness.

With a hyperfunctioning adrenal cortex, of which Cushing's syndrome is the prototype, the incidence of osteoporosis, hypertension, diabetes, hirsutism and protracted wound healing and the occurrence of renal stones were stressed. He directed attention again to the orthostatic hypotension, anorexia, nausea, pigmentation and x-ray evidence of a small heart in patients with ablation of or poorly functioning adrenals. Patients brought to the hospital in shock, no matter what the admitting diagnosis may be, should be investigated for possible associated and unrecognized adrenal insufficiency.

After syllogistically explaining the meaning of laboratory confirmation in all these diseases, Dr. Hoffman discussed the pharmacological action of corticosteroids including their anti-inflammatory, antiallergic, and antitoxic properties in doses greater than the 10-20 mg. a day physiological level. He pointed out that the only undesirable effects that so far had been separated from their pharmaceutical derivatives and synthetics had been certain water and electrolyte changes but that all other undesirable properties at least to date seemed to be part of total drug activity.

The afternoon speakers included Drs. M. Edward Davis, Douglas M. Buchanan and Ben Eiseman. Dr. Davis, who is chairman of the Department of Obstetrics and Gynecology at the University of Chicago School of Medicine, summarized his lecture on infertility for me as follows:

Infertility is still a major medical problem for the physician. It has been estimated that more than 10 per cent of married couples are involuntarily childless. The proper study of these individuals will make it possible for a third or more to have families. Age is an important factor in fertility, particularly in the female, and couples should be investigated when they consult the physician because of their inability to conceive.

A complete study of the husband and wife is the most productive facet of the management of the infertile couple. It can be carried out by the practitioner who is familiar with the normal physiology of human reproduction.

A detailed history is very important. In the woman it should include information concerning puberty and adolescence, the establishment of the menses, and their regularity and frequency. A history of previous unsuccessful pregnancies may be noteworthy. The sex life of the couple should be noted. The husband likewise should be interviewed concerning childhood illnesses such as mumps; the frequency and pattern of coitus and other pertinent data should be noted.

The diagnostic study should include a complete physical examination with emphasis on the pelvic organs. Perhaps the patient may have some physical impairment which would make pregnancy undesirable. A detailed study of the cervix and the cervical mucus may be rewarding. Thyroid function can be evaluated by determination of the basal metabolic rate. The patient is instructed how to keep a basal body temperature record so that data can be obtained about the menses,

ovulation, and the frequency and timing of coitus. Arrangements are made for the x-ray visualization of the uterine cavity and the fallopian tubes so that their normalcy and patency can be established.

The husband should have a complete physical examination with special emphasis on a study of the seminal fluid. This, too, can be carried out by the generalist, or he may be referred to a urologist.

A complete study of the couple is the most important part of their treatment. Factors which may decrease fertility and can be remedied should be treated. The basal body temperature record should be discussed with the patient and the fertile period pointed out. In the event that there are no serious impediments to conception, no therapy is indicated, for an intelligent study and discussion will remove much of the emotional tension which may decrease fertility.

The most common pathologic conditions which are responsible for sterility in the female are partial or complete blockade of the fallopian tubes, ovulatory abnormalities, uterine abnormalities or neoplasms and other pelvic pathology. These conditions may or may not be treated satisfactorily. In the husband the most common causes of infertility are abnormalities and deficiencies in spermatogenesis although the delivery of spermatozoa into the reproductive tract may be faulty.

Dr. Douglas N. Buchanan is Professor of Pediatrics and Neurology at the University of Chicago School of Medicine. His fanciful but erudite and instructive discourse on the nervous system, scintillating with Irish wit, disclosed a formidable Celtic conviction in all he had to say. The neuroblast early in utero has the opportunity of deciding whether it will become a neurone or one of the servants of the neurone, either an astrocyte or an oligodendroglial cell. The number of neurones to be present for the life of the individual is decided by the time the fetus first moves in utero for these cells are unable to reproduce. Destruction by any method results in their replacement with astrocytes. Of interest was his description of the constant banging and pushing about of these servant cells (the astrocyte and oligodendroglia) within their own spheres during the entire life of the nervous system as they effect repair and the electrical discharge of energy.

A differentiation of central and peripheral myelin was made in that the latter alone is repairable. An understanding of these things makes diagnosis and prognosis possible in all nervous diseases, the professor said.

Dr. Buchanan also made some interesting observations that bear repeating. In his opinion Dilantin is less than one third as good as phenobarbital in treating convulsions in children under three years of age, as marked ataxia occurs early in its use. Dr. Buchanan also thought that Cortef, 10 mg. three times a day, is the only steroid to be recommended in controlling jackknife convulsive seizure. He also commented on the usefulness of phenurone in this disease. Operative procedures for the small head to disrupt closed cranial sutures was condemned as physiologically unsound. The brain pushes the skull before it in its growth rather than expanding to follow the bones of the skull. Concerning the surgical intervention for hydrocephalus he was of the opinion that all such a procedure could hope to accomplish was to give mother nature two or three months to effect her own cure. Natural cures were numerically the same as the good results from such surgery. Dr. Buchanan's lecture was a masterpiece which I think has suffered badly from my attempt to reproduce it even in part.

The final speaker of the symposium was Dr. Ben Eiseman, chairman of the department of Surgery of the University of Kentucky College of Medicine in Lexington, Ky. Dr. Eiseman thought that there is still a place in surgery for cholecystotomy and he expressed the opinion that this procedure should not be considered a cowardly one. His philosophy concerning early cholecystectomy also was unique and reflected the importance of time in a world where time-space has lapsed even in recovery from disease.

The surgeon's knowledge of the newer concepts of bilirubin metabolism was interesting, and the importance of conjugation in recognition of certain disease entities particularly in the infant was stressed. Dr. Eiseman also discussed the current status of surgery for chronic pancreatitis and reviewed the available procedures. The end to end splitting of this organ to effect adequate drainage was recommended as the procedure of choice.

A panel discussion with participation from the audience followed both the morning and afternoon sessions.

Matthew E. Morrow Jr., M.D.
Jacksonville

News

Dr. Francis T. Holland of Tallahassee has been presented a special award commemorating his leadership as first chairman of the Florida Committee on Rural Health. Presentation ceremonies took place at the Committee's semi-annual meeting the middle of December at Tallahassee.

A Seminar on the Application of Basic Sciences to Clinical Practice has been scheduled for March 29-30 at the University of Florida College of Medicine in Gainesville. Areas to be discussed include hypertension, diabetes, cerebral vascular disease and cardiac problems. There will be case presentations and an evening round table program the first day of the Seminar.

Dr. Sanford Cobb of Miami, Associate Professor of Anesthesiology at the University of Miami School of Medicine, has been appointed Acting Chairman of the Department of Anesthesiology effective January 1.

The Air Reserve Forces in Florida need physicians to staff the medical position in the 13 Reserve Recovery Units established in this state in July, 1961. There are position vacancies in the rank of Major and Colonel. Each of the squadrons has a small medical section, and physicians with or without prior military service who are willing to participate in this program should contact the commander of the local squadron in his area. Participants will accrue credit toward retirement and also satisfy any unfilled obligation under the doctor draft. Location of units follow: 8443 Air Reserve Recovery Group Headquarters at Jacksonville with squadrons located at Tallahassee, Fernandina Beach, Gainesville and DeLand; 8445 ARRG Headquarters at Tampa with squadrons at Tampa, St. Petersburg and Lakeland; 8441 ARRG Headquarters at Miami with squadrons at Miami, West Palm Beach and Vero Beach.

Drs. Edward R. Woodward of Gainesville and John J. Farrell of Miami will participate in the program for the third of four 1962 sectional meetings of the American College of Surgeons being held March 26-28 at Memphis, Tenn. Dr. Woodward is a member of the panel which will discuss "Gastrointestinal Bleeding of Unknown Etiology," and Dr. Farrell will discuss "Neoplasms of the Breast" as a member of another panel presenting this subject on the closing day of the meeting.

Drs. DeWitt C. Daughtry of Miami and Hawley H. Seiler of Tampa were among the physicians from Florida attending the annual meeting of the Southern Thoracic Surgical Association held recently at Memphis. Dr. Daughtry, formerly president, has become chairman of the council, and Dr. Seiler was re-elected secretary-treasurer.

The Bascom H. Palmer Eye Institute for the study and treatment of diseases of the eye was dedicated January 21 and turned over to Dade County and the University of Miami School of Medicine by the Miami Lighthouse for the Blind. Dr. Edward W. D. Norton of Miami, Professor and Chairman of the Department of Ophthalmology at the medical school, is director of the Institute. It is a four story building costing over half a million dollars and provides 30,000 square feet for ophthalmologic outpatient facilities, research laboratories, an ophthalmology library and Florida's first eye bank.

The physician wanting to know more about a drug he wishes to employ can obtain any and all information he needs about any drug, at any time of the day or night, every day of the year from "Mediphone," a drug information center established in Washington, D. C., with nationwide service by telephone. Charter membership in the organization is $15 per year, deductible as a professional expense. Information is available from Mediphone, Inc., 1500 Massachusetts Ave., N.W., Washington 5, D.C.

The Annual Seminar of the Watson Clinic at Lakeland has been scheduled for March 3. Among the speakers on the program are Dr. Edward H. Rynearson, Chief of Medicine at Mayo Clinic; Dr. Paul Dudley White of Boston; Dr. Arthur C. Curtis of the University of Michigan, and Dr. Harold B. Boyd of the Campbell Orthopedic Clinic at Memphis.

Dr. Charles McC. Gray of Tampa has been installed as president of the Radiological Society of North America. Dr. Gray previously served as chancellor and as vice president.

(Continued on page 743)

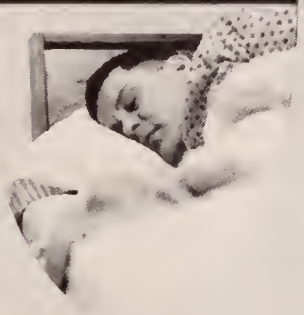
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ABBOTT

VI-DAYLIN—Vitamins A, D, B_1, B_2, B_6, B_{12}, C, and Nicotinamide, Abbott

(Continued from page 740)

Dr. Kenneth Phillips of Miami and Dr. Johnston L. Chereskin of Sarasota have been presented silver certificates by the American College of Gastroenterology signifying 25 years' continuous affiliation.

Dr. Richard G. Alper of Miami, a member of the first class graduated from the University of Miami School of Medicine, has been elected president of the newly formed Alumni Association.

Dr. Charles K. Donegan of St. Petersburg, president-elect of the American Society of Internal Medicine, is one of the speakers for the Third Annual Internists' Day being sponsored by the New York State Society of Internal Medicine March 3 at the Savoy Hilton Hotel, New York City. For the program, a Symposium on Thyroid Disease, seldom have as many experts been gathered for a one day meeting.

The Sixth Annual Arthur H. Weiland Lecture will be presented March 5, beginning at 8:00 p.m., at Variety Children's Hospital at Miami. The lecturer is Dr. William Thomas Green, the John Ball & Buckminster Brown Professor of Orthopedic Surgery at Harvard Medical School, and Orthopedic Surgeon-in-Chief at Children's Medical Center at Boston. Dr. Green will discuss "Growth and Development of Children Under Normal and Abnormal Conditions."

W. B. Saunders Company features the following books in its advertisement in this issue of The Journal: Fontana and Edwards, "Congenital Cardiac Disorders;" Williams, "Textbook of Endocrinology;" and 1962 Current Therapy.

Meetings

February

Cardiology and Endocrinology Symposium, Feb. 2-3, Cherry Plaza Hotel, Orlando

Fourth Annual Cardiovascular Seminar, Feb. 17-18, Hawaiian Village Motel, Tampa

March

Annual Seminar, Watson Clinic, March 3, Lakeland.

Post Graduate Cardiac Surgical Colloquia, March 10 and March 24, Pathology Conference Room, Jackson Memorial Hospital, Miami

Seminar on the Application of Basic Sciences to Clinical Practice, March 29-30, College of Medicine, University of Florida, Gainesville

April

Post Graduate Cardiac Surgical Colloquia, April 14 and April 28, Pathology Conference Room, Jackson Memorial Hospital, Miami



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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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Gruendel, Donald P., Tampa
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Spertus, Irving, Clearwater
Tylar, Norman E., Lake Placid
Wolk, Harry E., Miami Beach

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Camp, Robert J., Coral Gables
Cesarano, Francis L., Miami
Fleisher, Harvey A., Miami
Flipse, Thomas E., Miami
Ford, J. Clark, Lake Worth
Friedman, Gilbert R., Miami Beach
Garcia, David E., North Miami
Gentsch, Thomas O., Coral Gables
Goddard, Arnold R., Miami
Gordon, Howard L., Miami
Holford, Fred D., Delray Beach
Hutson, E. Douglas, Miami
Jacobs, Robert H., Coral Gables
James, Edward M., Miami Springs
Jones, Paul K., West Palm Beach
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Kollar, Charles S., Sarasota
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McConville, Edward B., West Palm Beach
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Nonkin, Paul M., Coral Gables
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition, W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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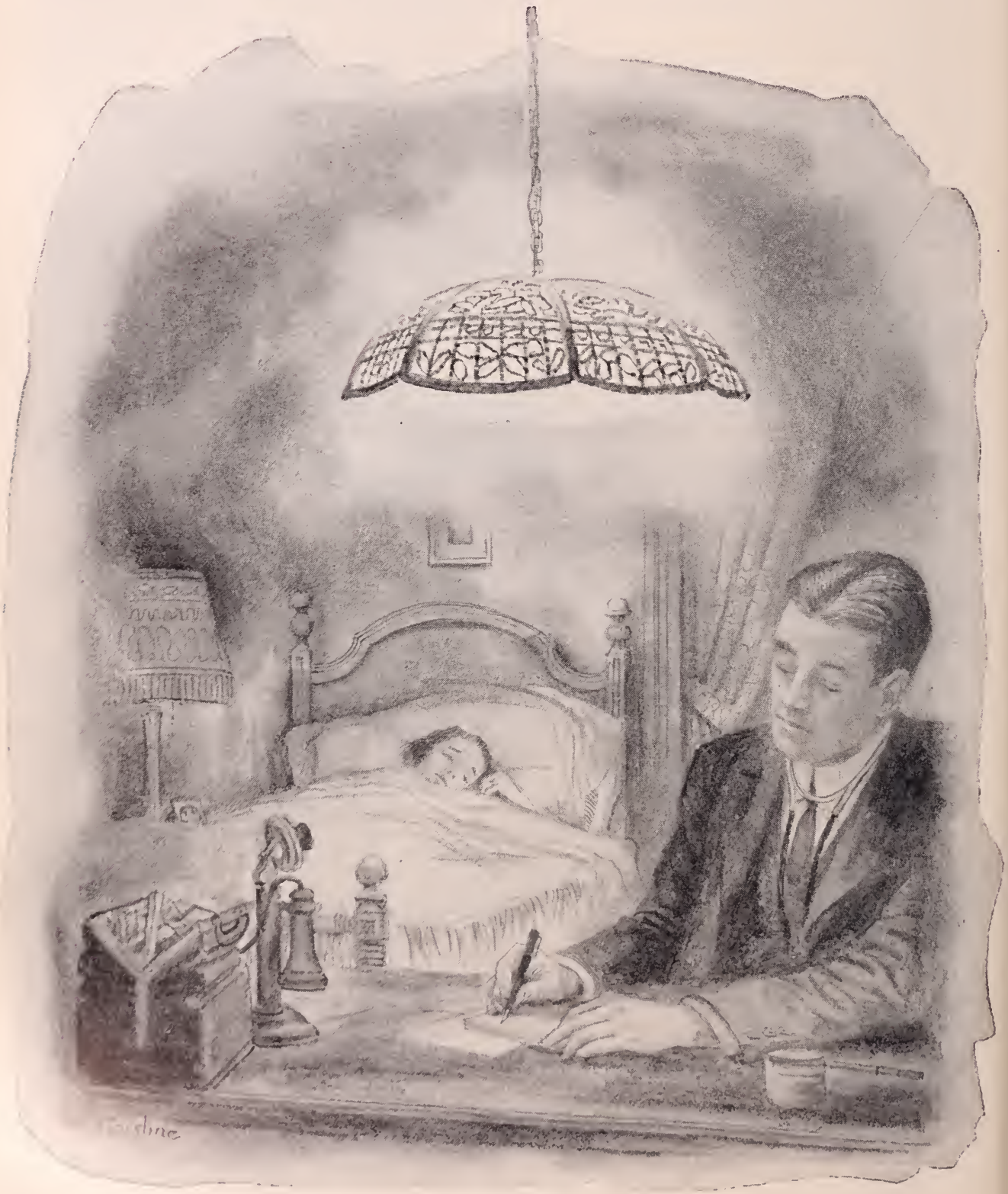
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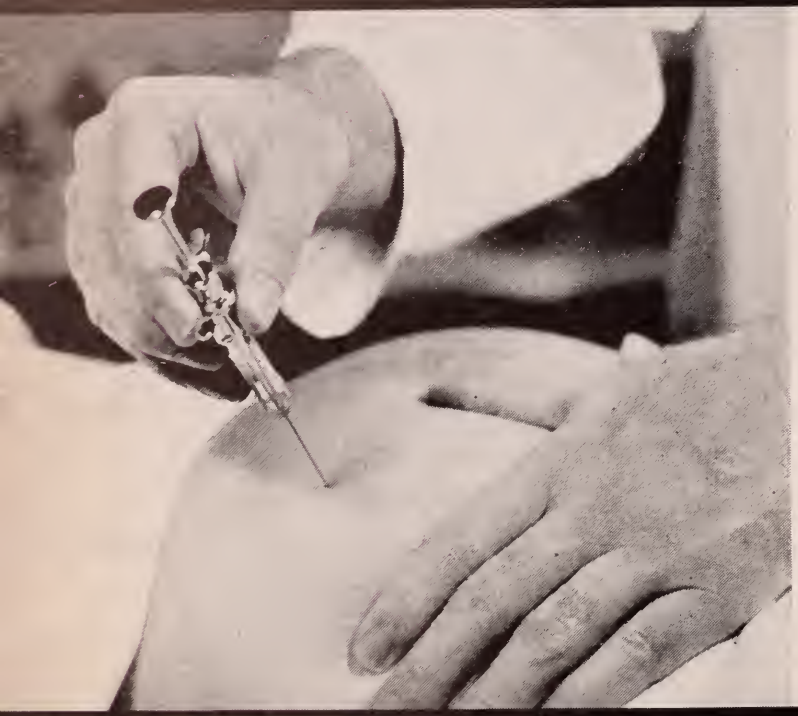
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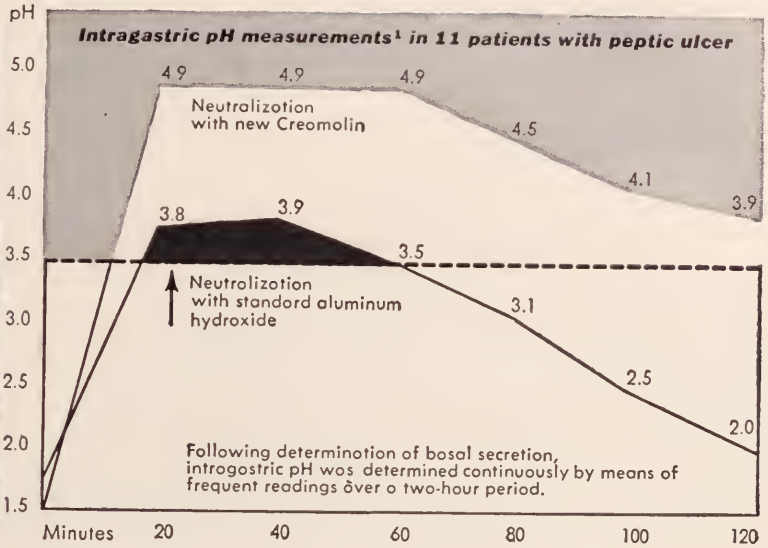
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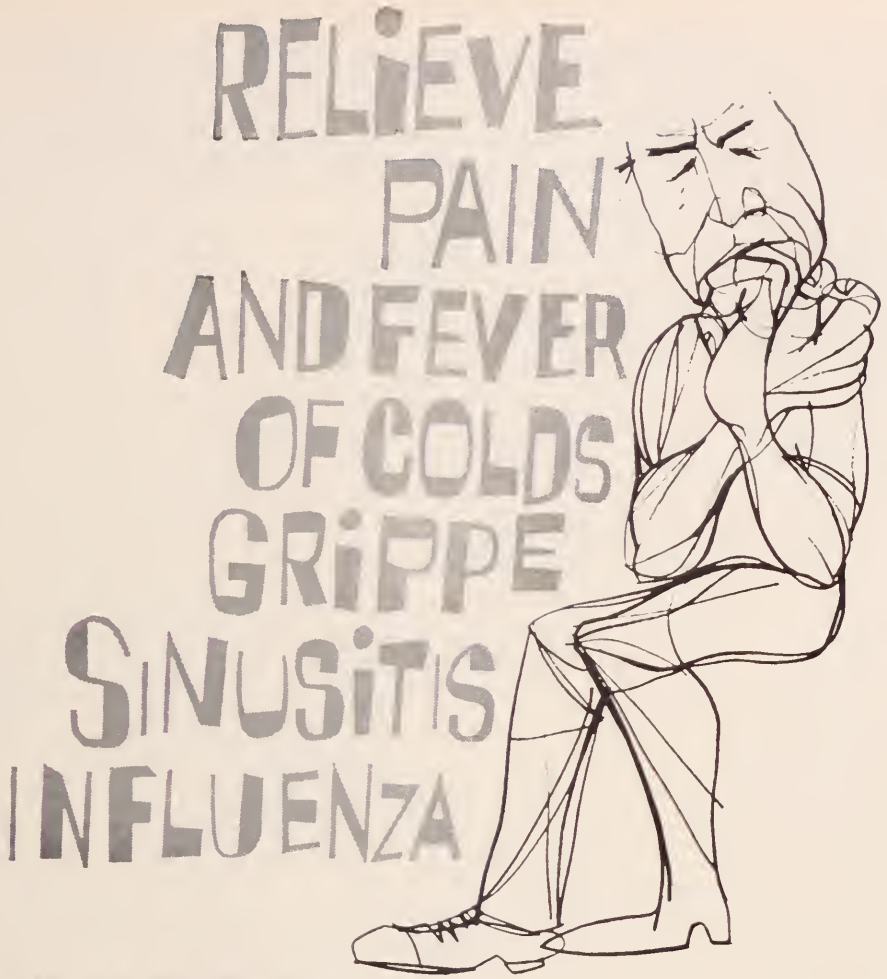
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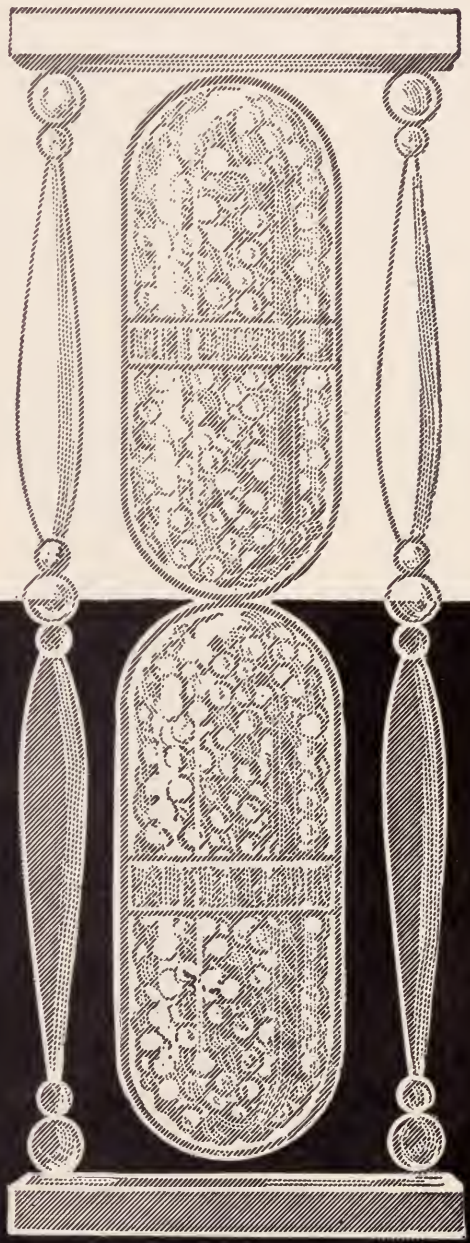
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SUPPLY: PREDLON 5 mg. is available in bottles of 30 and 100 Pelsules.

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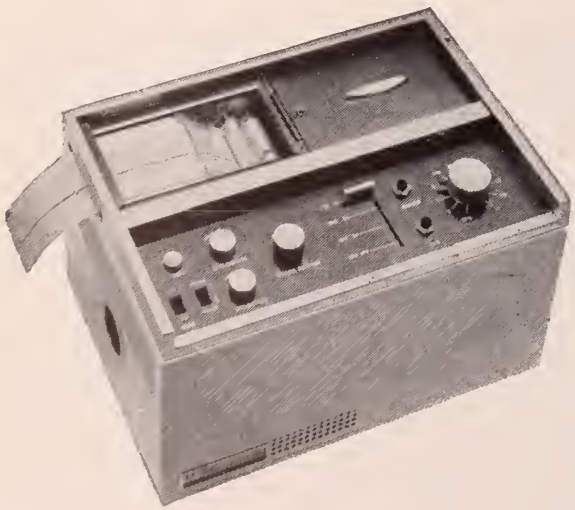
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Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

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Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
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Hydrocholeretic • Antispasmodic • Sedative...to reduce *TENSION* and anxiety-induced dysfunction of G.I. and biliary tracts...and also relieve both smooth-muscle *spasm* and biliary/intestinal *stasis*

butabarbital sodium ..... 15 mg. (¼ gr.)
(Warning–may be habit forming)
dehydrocholic acid, AMES .....250 mg. (3¾ gr.)
belladonna extract ..... 10 mg. (⅙ gr.)

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Hydrocholeretic–Antispasmodic...to relax *SPASM* of smooth muscle of G.I. tract and sphincter of Oddi...and also counteract biliary/intestinal *stasis*

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belladonna extract ..... 10 mg. (⅙ gr.)

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Hydrocholeretic...to combat *STASIS* in bowel and biliary tract...by activating biliary function with a greatly increased flow of aqueous "therapeutic" bile

dehydrocholic acid, AMES .....250 mg. (3¾ gr.)

Average adult dose: 1 or, if necessary, 2 tablets three times daily.

Side effects: DECHOLIN by itself, or as an ingredient, may cause transitory diarrhea. Belladonna in DECHOLIN with Belladonna and DECHOLIN-BB may cause blurred vision and dryness of mouth.

Contraindications: Biliary tract obstruction, acute hepatitis, and (for DECHOLIN with Belladonna and DECHOLIN-BB) glaucoma.

Precautions: Periodically check patients on DECHOLIN with Belladonna and DECHOLIN-BB for increased intraocular pressure. Also observe patients on DECHOLIN-BB for evidence of barbiturate habituation or addiction, and warn drivers against any risk of drowsiness.

Available: DECHOLIN-BB, in bottles of 100 tablets; DECHOLIN with Belladonna and DECHOLIN, in bottles of 100 and 500.

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A patient treated with Librium feels different, even after a few doses. He appears different to his family and to his physician. Different, in the sense of a change from the previous state of anxiety and tension, and also freed from the sensations created by daytime sedatives or tranquilizers. That the striking difference in Librium was first observed in a series of ingenious animal experiments is mainly of theoretical interest. Of more practical importance, for example, is that Librium lacks any depressant effect—a fact which can assume overriding clinical importance. And this is but one of the ways in which the difference can be observed.

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Consult literature and dosage info available on request, before pre

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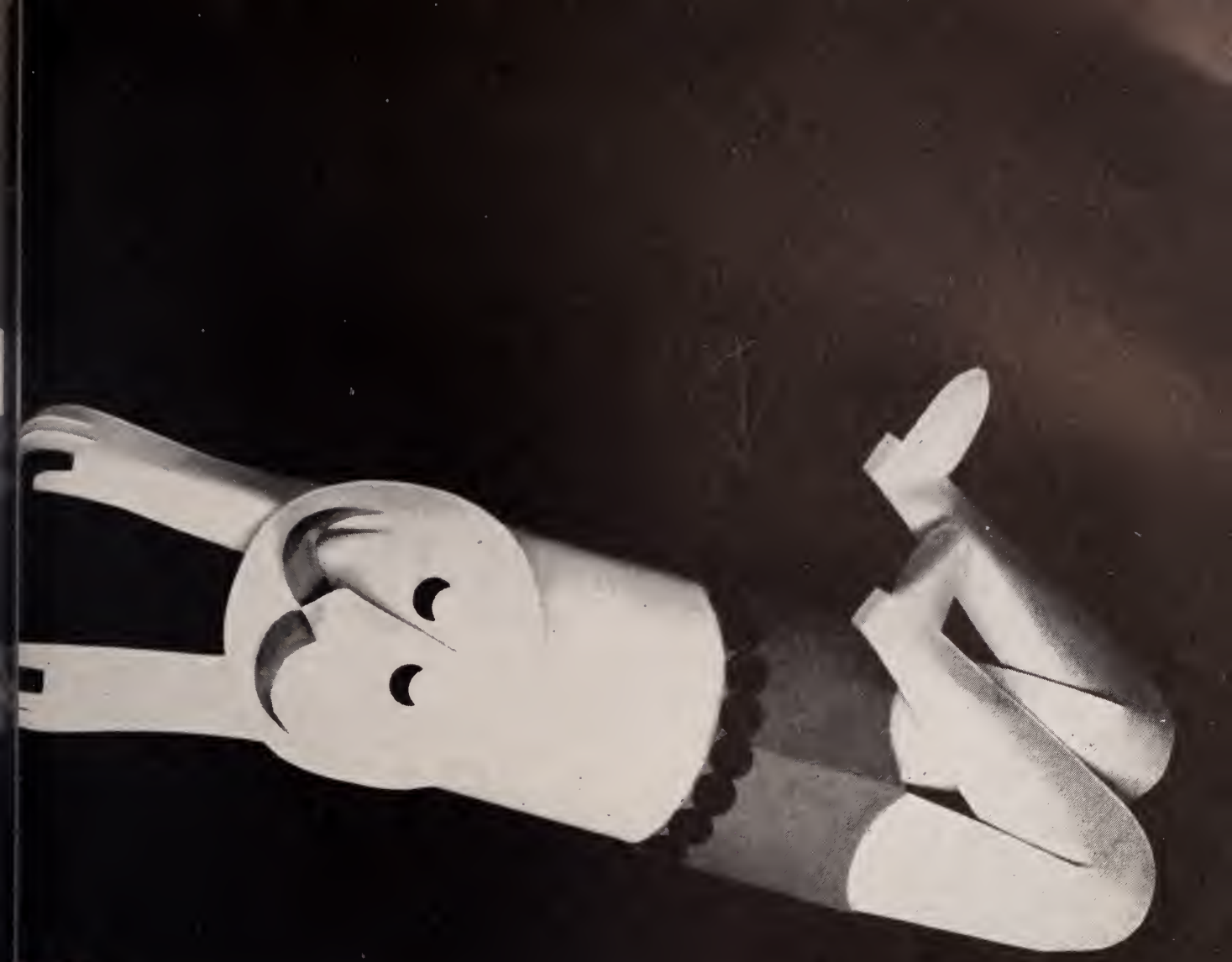
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is threatened by a cough...



Benylin® Expectorant

provides the right combination for effective cough control

Your patient probably has a more "down-to-earth" occupation than the trapeze artist, but persistent coughing can cause a comparable drop in performance. Not so when you prescribe BENYLIN EXPECTORANT. This outstanding antitussive preparation effectively suppresses coughs due to colds or allergy through its combination of judiciously selected ingredients.

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BENYLIN EXPECTORANT contains in each fluidounce:

Benadryl® hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	80 mg.
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Sodium citrate	5 gr.
Chloroform	2 gr.
Menthol	0.1 gr.
Alcohol	5%

Supplied: BENYLIN EXPECTORANT is available in 16-ounce and 1-gallon bottles.

This advertisement is not intended to provide complete information for use. Please refer to the package enclosure, medical brochure, or write for detailed information on indications, dosage, and precautions.

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When it's more like "grippe" or



"flu" than a simple cold, but an antibiotic is not indicated... prescribe NEW WIN-CODIN* Tablets

New Win-Codin tablets provide greater symptomatic relief from influenza, colds and sinusitis than do simple analgesic-antihistamine combinations. New Win-Codin tablets contain a full complement of the most effective agents available to relieve general discomfort, bring down fever and lessen congestive symptoms.

Each tablet contains:

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Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

Winthrop LABORATORIES
New York 18, N. Y.

*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

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THE Journal OF THE FLORIDA MEDICAL ASSOCIATION

VOLUME XLVIII, No. 9

• *March, 1962*

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FORMULA: *Each 15 cc. (tablespoon) contains:*

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(equivalent to 2 cc. paregoric)	

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

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Winthrop LABORATORIES
New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



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Exempt Narcotic. Available on Prescription Only.



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in anxiety and depression

The outstanding effectiveness and safety with which Miltown calms tension and nervousness has been clinically authenticated by thousands of physicians during the past six years. This, undoubtedly, is one reason why meprobamate is still the most widely prescribed tranquilizer in the world.

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Vitamin B_{12}	2 mcg.
Folic Acid	0.33 mg.
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Choline Bitartrate	20 mg.
Inositol	15 mg.
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Riboflavin	5 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
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Each Filmtab represents all the vitamins of Optilets plus the following:

Iron (as sulfate)	10 mg.
Copper (as sulfate)	1 mg.
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Cobalt (as sulfate)	0.1 mg.
Manganese (as sulfate)	1 mg.
Magnesium (as oxide)	5 mg.
Zinc (as sulfate)	1.5 mg.
Molybdenum (as sodium molybdate)	0.2 mg.



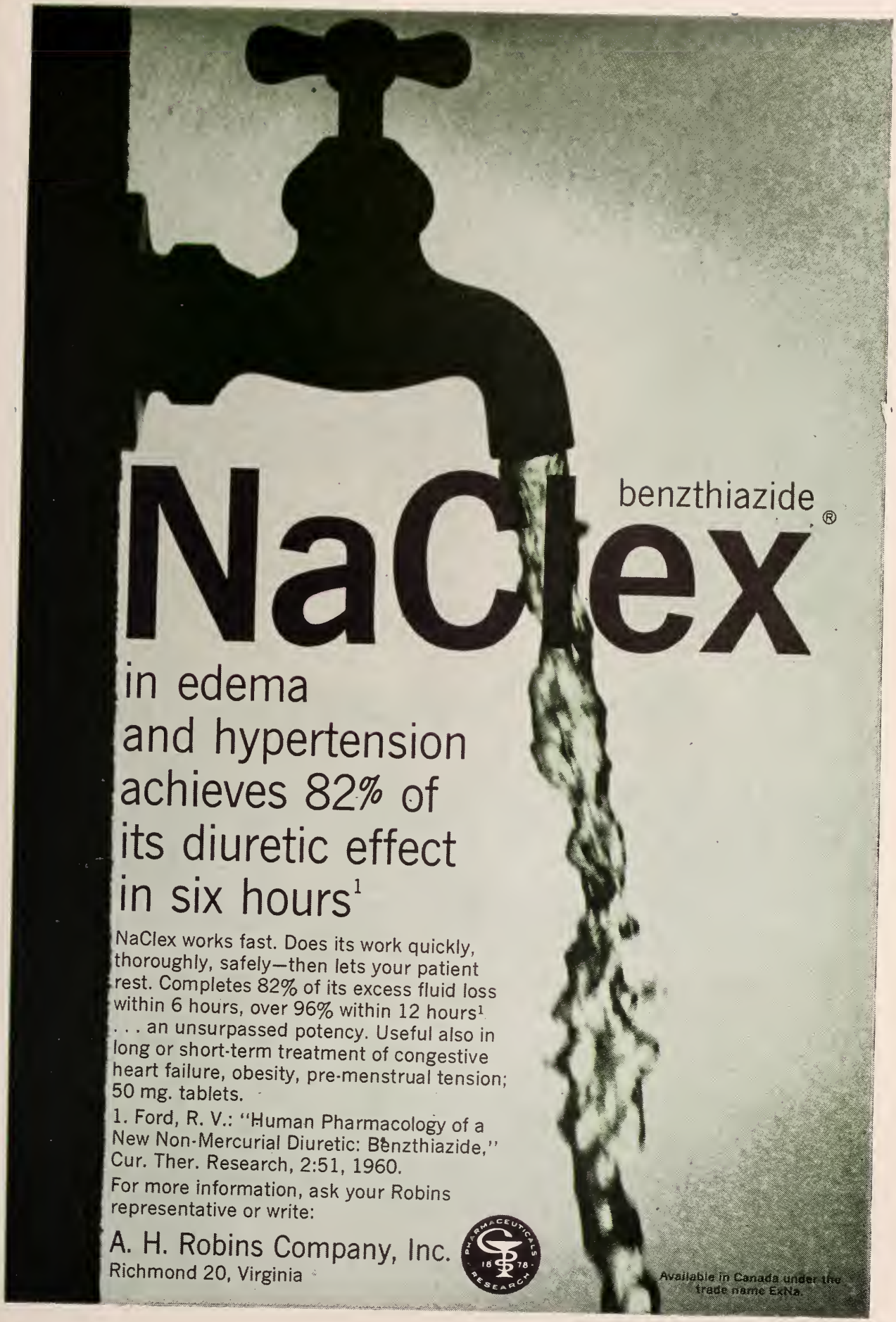
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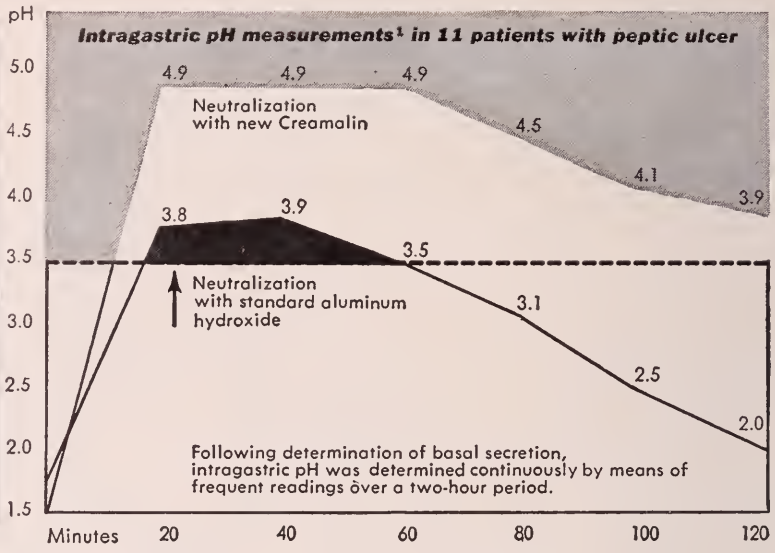
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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New Creamalin®

Antacid Tablets

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takes up more acid

Heals ulcer fast—action more prolonged *in vivo*

Has superior action of a liquid, with the convenience of a tablet[5]

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. New Creamalin tablets are pleasant tasting and smooth, not gritty. They do not cause constipation or electrolyte disturbance.

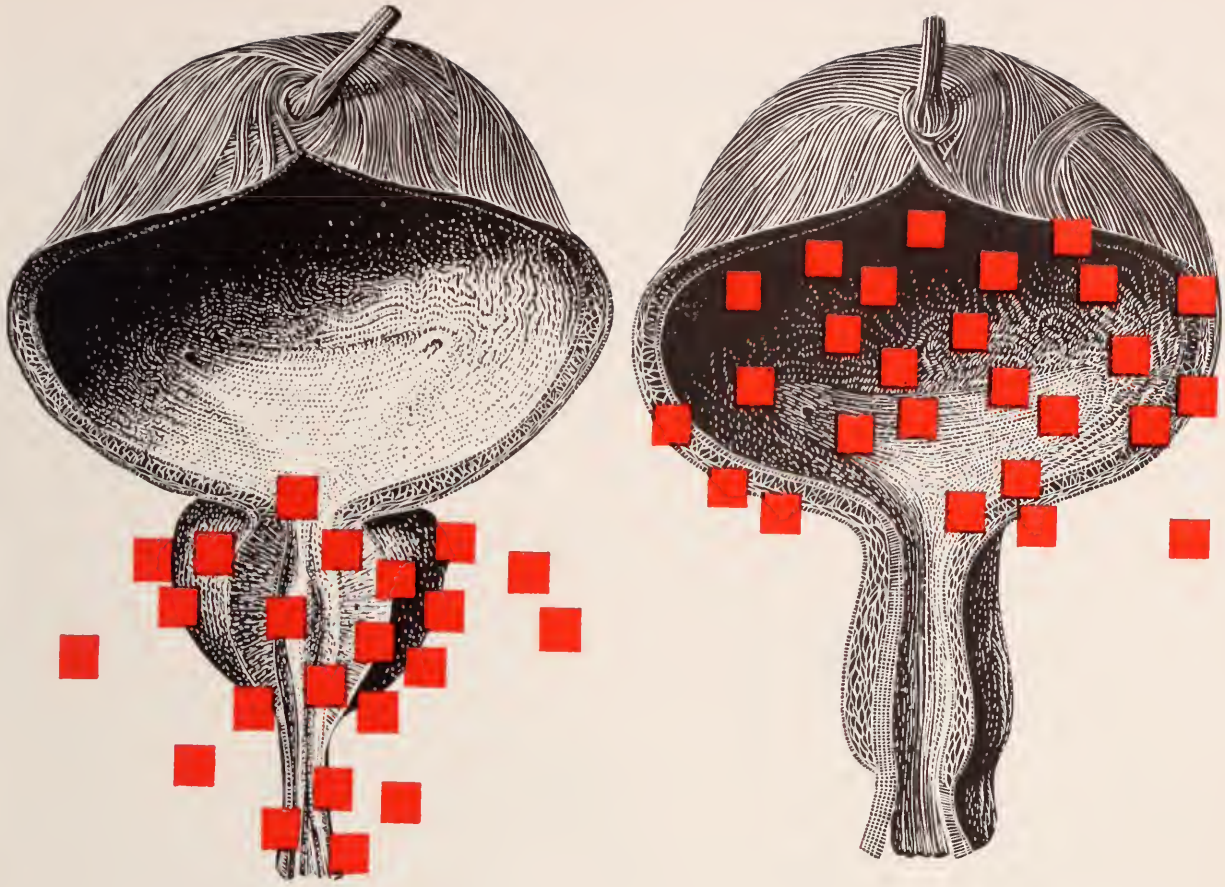
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References: 1. Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. 2. Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. 3. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. 4. Data in the files of the Department of Medical Research, Winthrop Laboratories. 5. Hinkel, E. T., Jr. ; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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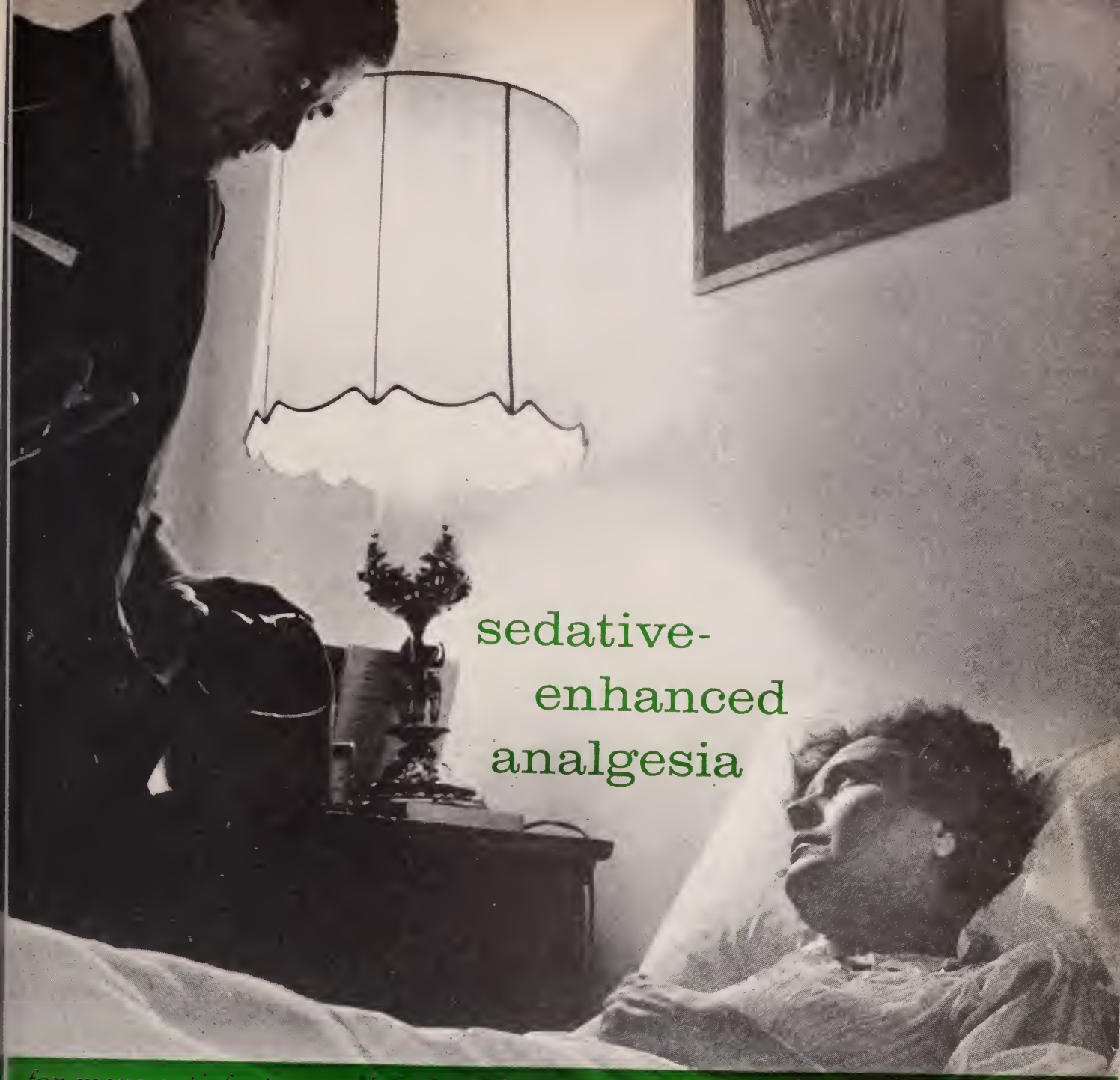
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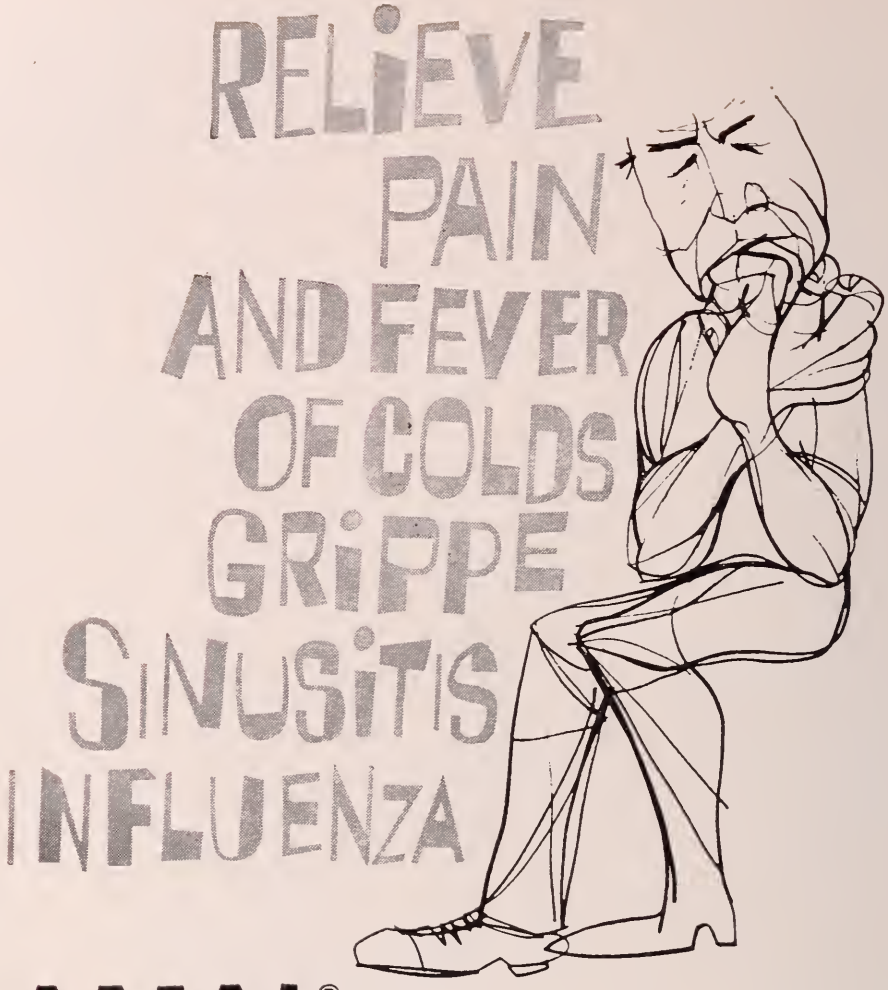
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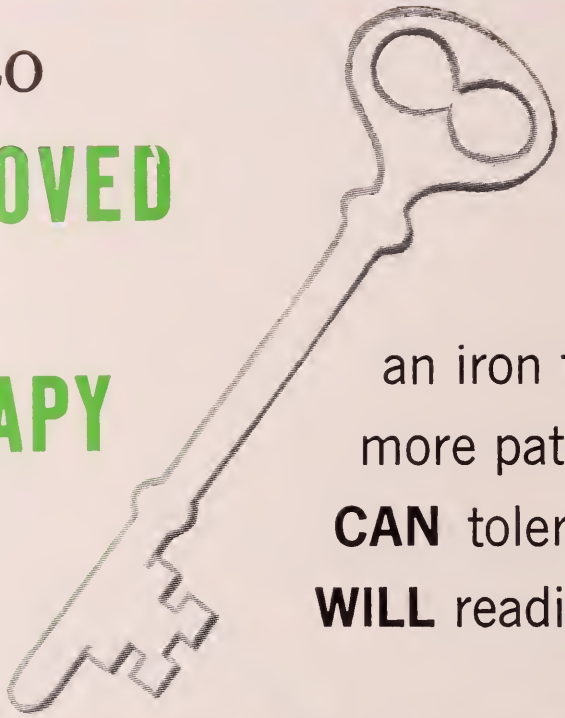
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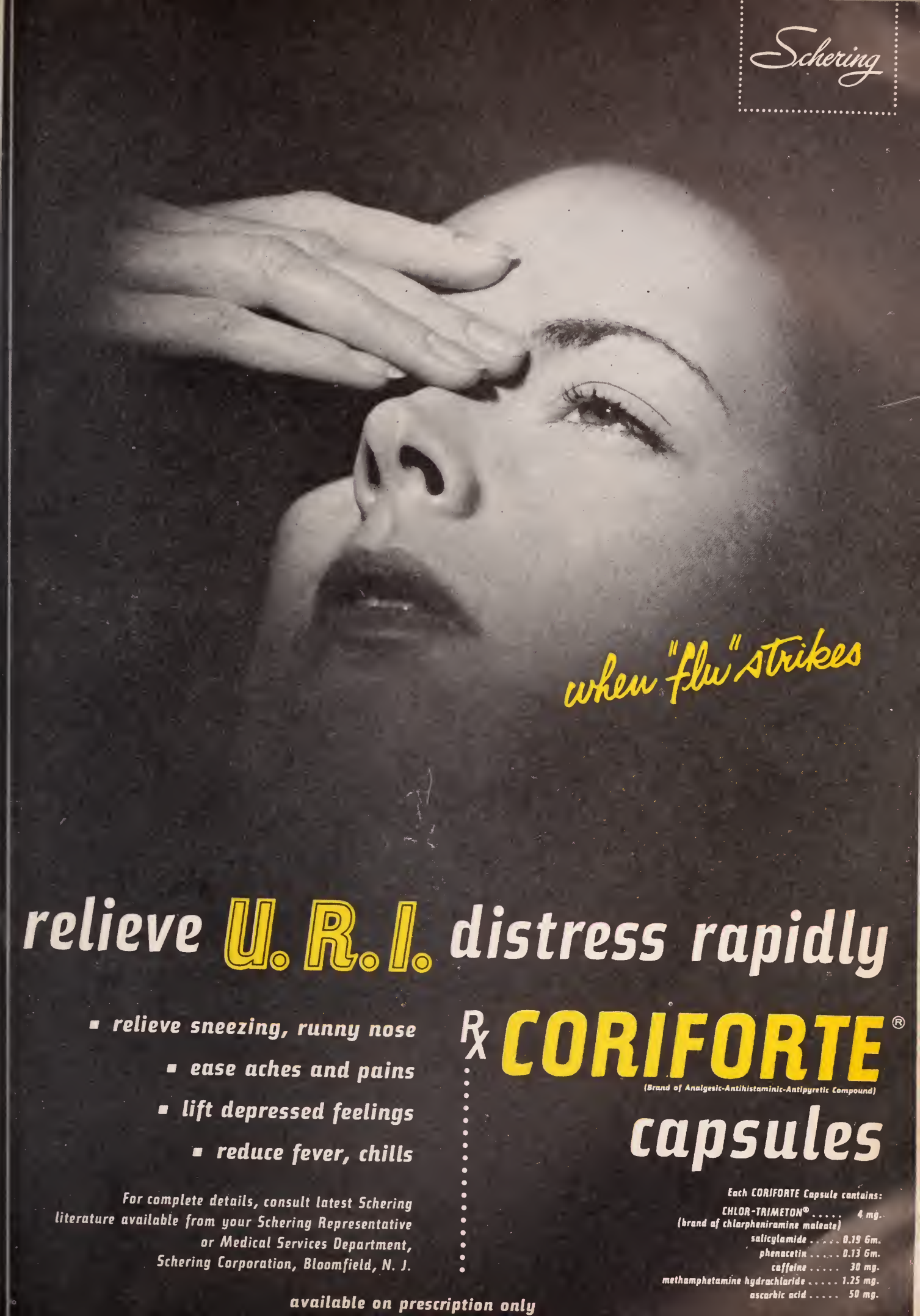
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Volume XLVIII, No. 9, March, 1962

Blood Volume Determination and Its Surgical Significance

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AND ROBERT H. ANDERSON JR., M.D.
JACKSONVILLE

The early attempts at measurement of blood volume date back to 1838, when Valentin estimated volume from changes in the concentration of whole blood following an infusion of large known volumes of fluid.[1] Aside from the fact that the procedure altered blood volume, it had other features which made interpretation of results uncertain. Probably the greatest single stimulus to investigation of blood volume was the dye method (vital red and brilliant vital red) introduced in 1915 by Keith, Rountree and Gerharty.[2] Since then, T-1824, radio-iodinated serum albumin (RISA), radioactive chromium and other isotopes have been introduced into clinical use. Only recently has blood volume come into wide play, because physicians are more physiologically inclined than in the past. The use of RISA is a rapid and relatively accurate method that has recently become available on our service. With the introduction of this method, the procedure was rapidly appreciated but at times quite perplexing until extensive review of the literature brought numerous new and forgotten facts to light.

Method

Our method of determining blood volume was by utilizing radioactive iodinated human serum albumin (RISA). This method employs the injection of a known amount of diluted RISA into an antecubital vein (10 cc. of diluent containing 10 microcuries of RISA) and withdrawal of 10 cc. of the patient's blood from the opposite antecubital vein a minimum of 10 minutes later. In order to allow for proper equilibration another 10 cc. of the diluent is further diluted to 1,000 cc. with normal saline to serve as a standard. Equal parts of the patient's blood and the standard, usually 4 cc., are then taken and the radioactivity of each is measured using a scintillation counter and a well type chamber. A background count also is obtained, and the standard minus this count is equal to the net count times 1,000. The radioactivity count of the blood minus the background count equals the net count of blood. Then 1,000 times the net count of the standard over the net count of the blood equals the total circulating blood volume in cubic centimeters.

If a patient has had a previous volume determination, a blank is drawn prior to injection of the RISA (as a control) and the net count of this is substracted from the net count of the second volume specimen.

Venous hematocrit determinations of the same date were used to calculate the total red cell volume. No correction of red cell volume or total blood volume was made for the known discrepancies between the venous and the total body hematocrit levels.[3,4]

Results
Evaluation (Group I)

The patients in Group I were placed in this category simply because we were attempting to ascertain whether their blood volumes prior to a surgical procedure, after numerous transfusions, following an operation, or as a consequence of a particular disease fell within an acceptable range of normal. Since we were truly sizing these pa-

Read before the Florida Medical Association, Eighty-Seventh Annual Meeting, Miami Beach, May 26, 1961.

Table 1.—Group I: Evaluation

Patient Number Age, Sex, Race	Diagnosis	Date	Weight in Kg.	Hemat-ocrit	Estimated Blood Volume	Calculated Blood Volume	Comment
Case 1 Negro 52 Yrs. M	Carcinoma of tongue	1/26/61	55	42	3,850 cc.	4,200 cc.	Postoperative volume determination. Shock; blood given without effect. Cerebral edema
Case 2 White 53 Yrs. M	Bleeding varices	4/25/60	73	33	5,110 cc.	4,239 cc.	Received 21 pints of whole blood prior to first volume determination and 1 unit of whole blood and 1 unit of packed red cells between second and third determinations. Hematemesis occurred on May 19. Lost weight steadily during convalescence
		4/27/60	73	31	5,110 cc.	3,915 cc.	
		5/ 9/60	73	38	5,110 cc.	4,532 cc.	
		5/19/60	73	19	5,110 cc.	1,860 cc.	
		5/20/60	73	30	5,110 cc.	4,770 cc.	
		5/24/60	73	42	5,110 cc.	5,844 cc.	
Case 3 Negro 66 Yrs. F	Fibrosar-coma with metastases	7/13/60	55	36	3,575 cc.	3,617 cc.	No loss in weight. Hepatomegaly. Preoperative volume determination
Case 4 White 75 Yrs. M	Common duct obstruction	5/12/60	65	40	4,550 cc.	4,890 cc.	Preoperative volume determination. Mild hypertension
Case 5 Negro 57 Yrs. M	Obstructive jaundice	5/ 8/60	61	29	4,270 cc.	7,793 cc.	Received 3,500 cc. of blood preoperatively. Bled from liver biopsy. Volume determination after blood was administered
Case 6 White 58 Yrs. M	Bronchogenic carcinoma	6/27/60	65	38	4,550 cc.	7,146 cc.	Had lost 13.6 Kg. in weight. First blood volume determination in error. Second volume determination after 2,000 cc. of blood administered
		6/29/60	65	41	4,550 cc.	5,776 cc.	
Case 7 Negro 32 Yrs. M	Gunshot wound of abdomen	4/ 5/60	83	58	5,611 cc.	5,945 cc.	Postoperative volume determination and phlebotomy. High hematocrit level. Much bile drainage through chest. Cirrhosis
Case 8 Negro 30 Yrs. M	Gunshot wound of abdomen	7/ 9/60	70	38	4,900 cc.	4,008 cc.	Received 950 cc. of blood before first volume determination and 20 units of blood and 2 units of plasma between first and second volume determinations
		7/10/60	70	45	4,900 cc.	4,945 cc.	
Case 9 Negro 53 Yrs. M	Gastrointes-tinal bleeding	2/26/60	55	33	3,850 cc.	5,623 cc.	Received 21 pts. of blood prior to and was receiving blood during volume determination. Hematocrit level next day was 30
Case 10 White 80 Yrs. M	Carcinoma of rectum	9/26/60	57	34	3,990 cc.	5,429 cc.	Much edema increased plasma volume. Between first and second volume determinations 2 units of blood given in divided doses
		10/ 6/60	57	40	3,990 cc.	4,359 cc.	
Case 11	Gastric	11/10/60	84	33	5,460 cc.	10,900 cc.	Had portal hypertension. Eight months pregnant. Prior

White	Final bleeding						lonephritis
Case 13 Negro 61 Yrs. F	Gastric ulcer with hemorrhage	11/ 8/60	48	22	3,500 cc.	2,240 cc.	After administration of 1,500 cc. of blood, hematocrit level rose to 37
Case 14 Negro 40 Yrs. F	Carcinoma of sigmoid	11/ 8/60	47	24	3,431 cc.	2,712 cc.	Malnourished. After 3 units of blood given, hematocrit level rose to 40
Case 15 Negro 78 Yrs. F	Ulcer on heel	5/ 5/60	61	41	3,965 cc.	2,870 cc.	Received 3 units of blood over a three day period. Pressure finally stabilized.
Case 16 Negro 60 Yrs. M	Carcinoma of larynx	9/13/60	54	45	3,800 cc.	4,782 cc.	Preoperative volume determination with 2 units of blood given during procedure. Weight loss unknown
Case 17 Negro 37 Yrs. F	Gunshot wound of chest	7/11/60	54	40	3,510 cc.	2,772 cc.	Received 14 pts. of blood prior to volume determination and 2 more later. Made good recovery
Case 18 Negro 53 Yrs. M	Carcinoma of stomach	5/23/60	61	33	5,250 cc.	5,611 cc.	Lost 13.6 Kg. in weight. Widespread metastases. Hepatomegaly
Case 19 White 54 Yrs. F	Carcinoma of colon	6/ 8/60	56	50	3,640 cc.	3,920 cc.	Received 1,000 cc. of blood prior to and 500 cc. during postoperative volume determination. Hematocrit evaluation probably incorrect
Case 20 Negro 32 Yrs. M	Laceration of internal-external jugular vein	4/30/60	68	41	4,760 cc.	5,256 cc.	Patient in shock. Blood and dextran administered rapidly. Falsely high blood volume determination
Case 21 Negro 80 Yrs. M	Carcinoma of esophagus	5/28/60 5/30/60	52 52	53 45	3,640 cc. 3,640 cc.	4,236 cc. 3,756 cc.	Following first blood volume determination, 300 cc. of blood drawn. Received 500 cc. of plasma. Postoperative volume determinations
Case 22 White 32 Yrs. M	Pancreatic cyst	9/10/60	50	39	3,500 cc.	4,051 cc.	Loss in weight 21.8 Kg. Heavy alcohol intake. Extra plasma volume
Case 23 Negro 75 Yrs. M	Gastrointestinal bleeding	5/23/60	56	29	4,088 cc.	5,767 cc.	Blood volume determination made while patient was receiving blood rapidly. Congestive heart failure
Case 24 White 76 Yrs. M	Bleeding varices	7/20/60	72	30	5,040 cc.	4,567 cc.	Received 500 cc. of blood prior to volume determination

Case 25 Negro 48 Yrs. M	Stab wound of liver	5/16/60	75	40	5,250 cc.	5,496 cc.	Volume determination made while patient was in shock. Improved after 2 more units received, but probably would have done as well without
Case 26 White 45 Yrs. F	Cholecystitis, pulmonary infarct	9/19/60	73	42	4,745 cc.	4,034 cc.	Maintained on Levophed. Anoxia and venous constriction
Case 27 Negro 34 Yrs. M	Gastrointestinal bleeding	5/23/60	103	35	7,210 cc.	6,778 cc.	Received 13 pts. of blood and underwent gastrectomy prior to volume determination
Case 28 White 58 Yrs. M	Carcinoma of colon with obstruction	2/20/61	67	40	4,690 cc.	5,595 cc.	Large bowel obstruction. Volume determination believed false on basis of human error
Case 29 White 74 Yrs. M	Bronchogenic carcinoma	11/ 9/60	60	40	4,200 cc.	4,333 cc.	Normal volume determination. No loss in weight
Case 30 Negro 85 Yrs. M	Bilateral inguinal hernia	2/20/61	59	34	4,130 cc.	4,746 cc.	Slight increase in plasma volume determination. Probably slight loss in weight
Case 31 Negro 65 Yrs. F	Cancer of colon	2/28/61	58	38	3,800 cc.	4,047 cc.	Normal preoperative volume determination
Case 32 White 48 Yrs. F	Cancer of colon with metastases	12/ 1/60	33	44	2,145 cc.	2,712 cc.	Hematocrit level 27 two days earlier. Received 2,500 cc. of blood prior to volume determination
Case 33 Negro 82 Yrs. F	Rectal bleeding	4/ 6/61	94	30	6,110 cc.	6,406 cc.	Hematocrit level 26 on admission. Received 2 units of blood and 3 units of packed cells prior to volume determinations
Case 34 Negro 60 Yrs. F	Rectal stenosis with perforated rectosigmoid	3/28/61	47	43	3,055 cc.	3,402 cc.	Preoperative volume determination. Purulent material in abdomen at operation. Volume determination should be lower
Case 35 White 80 Yrs. F	Common duct stone and cholangitis	1/17/61 2/ 1/61	76 76	42 31	4,940 cc. 4,940 cc.	5,765 cc. 3,872 cc.	In shock four days (septic). Maintained on Aramine. Pancreatitis developed on second postoperative day
Case 36 Negro 47 Yrs. M	Gunshot wound of chest with organized hemothorax	3/20/61	68	33	4,750 cc.	3,884 cc.	Chest tapped in emergency room; 1,000 cc. of blood withdrawn. Two units of blood given prior to volume determination

tients up, volumetrically speaking, "evaluation" seemed the logical label to attach to this group.

To calculate the normal volumes we chose to use percentage times body weight in kilograms. For males the percentage is seven and for females six and one-half. In other words a man weighing 70 Kg. would have approximately 4,900 cc. of total blood volume. Even normal volumes vary considerably,[5,6] and this fact will be elaborated upon later. A variance of several hundred cubic centimeters was not considered abnormal and was expected.

From the 36 cases listed in the evaluation group (table 1) examples are presented of variants which are helpful in interpretation. The categories into which these fell were six: (1) normal, (2) true hypervolemia, (3) human or laboratory error, (4) relative hypervolemia, (5) pathophysiologic states tending toward hypervolemia, and (6) true hypovolemia.

Over 36 volume determinations (table 1) do not correspond to our calculated normal limit. This number constitutes nearly 76 per cent of the group and should not be considered unusual for the volume determinations obtained in this series were for the purpose of treatment and not to create a series of normals. There were instances where correlation did occur, such as in cases 1, 4 and 27. In case 1 volume was determined postoperatively because of a decline in blood pressure and showed excellent balance. In spite of this an extra pint of blood was given without effect, and administration of metaraminol (Aramine) was necessary; two days later for no explicable reason the pressure became stabile. Since a bilateral radical neck dissection had been performed, the decline in pressure was thought to be due to probable cerebral edema; so the volume determination was accurate. In case 4, the volume determination also correlated accurately. It was obtained preoperatively, and since there had been no loss in weight or blood, the volume determination was normal in every sense. In case 27, the volume determination was only 325 cc. less than the predicted norm. The patient had received 13 pints of blood and had been subjected to gastrectomy prior to determination of this volume. This case illustrates two points, that the clinical evaluation on the part of the surgeon was accurate and that there was no further active bleeding.

The importance of a normal blood volume determination lies not in the exact number of cubic centimeters but rather in its comparative reference value. This is borne out in case 5. The patient bled following a closed liver biospy and received some 3,500 cc. of blood prior to laparotomy. Hypotension ensued during the operation, and as indicated on clinical grounds, a phlebotomy was performed with some improvement. Since the pressure was still precarious, another phlebotomy was performed following determination of the blood volume, which was markedly elevated. If we had had no method of predicting the normal volume, we might well have attributed the postoperative shock to loss of blood. Unfortunately, the patient died but with the proper therapy (phlebotomy) being applied. This is an example of true hypervolemia.

Further support of the values of normal volume appears in case 6, showing over 2,500 cc. of extra volume. We knew that this patient had lost 13.6 Kg. in weight and physiologically, a person losing this much weight should have a relative increase in plasma volume. He should, however, have a hematocrit level somewhat lower than 38. This then was an obvious error. The reason is obscure, but we are inclined to believe that the technique of administration of the radioactive material was at fault. This view is substantiated by the second volume determination which was much lower and was obtained after 2,000 cc. of blood had been given at the operating table. In judging volume one must be painfully aware of the factor of human error.

Another category of this series is relative hypervolemia. In cases 9 and 23 there was a similar increase in blood volume; however, both of the patients were actively bleeding from the gastrointestinal tract, and both volume determinations were obtained while blood was running rapidly. These two factors in themselves are enough to give a falsely high volume. Physiologic conditions superimposed on pathologic states may also contribute to the relative hypervolemia. In case 11, 10,900 cc. is a tremendously high volume even for the weight given, and though there were some fluids in progress, they were not going in rapidly enough to have real effect. An immediate recheck of the volume revealed 10,500 cc. — obviously not an error in technique or administration. If the physiologic state is considered, a plausible explanation arises. The patient was in her last trimester of pregnancy, as well as having hepatosplenomegaly. Caton and his associates[7] showed that there is a progressive volume in-

Table 2.—Group II: Malnutrition

Patient Number Age, Sex, Race	Diagnosis	Date	Weight in Kg.	Hematocrit	Estimated Blood Volume	Calculated Blood Volume	Comment
Case 1 White 47 Yrs. F	Carcinoma with bony metastases	2/17/61	47	24	3,055 cc.	2,396 cc.	Weight loss 16 Kg. Marked depression of red blood cells
Case 2 White 55 Yrs. F	Carcinoma of cervix stage I	8/ 5/60	45	31	2,925 cc.	3,783 cc.	Weight loss 11.4 Kg. in six months
Case 3 Negro 47 Yrs. M	Carcinoma of esophagus	9/21/60	36	31	2,520 cc.	2,747 cc.	Weight loss 13.6 Kg. in four months. Received 2 units of whole blood prior to volume determination
Case 4 White 65 Yrs. M	Cirrhosis, diabetes	4/28/60	55	36	3,850 cc.	6,200 cc.	Received 600 cc. of plasma the day before volume determination. Ascites. Cachetic in appearance.
Case 5 Negro 59 Yrs. M	Hemochromatosis, diabetes	2/29/60	63	50	4,410 cc.	5,754 cc.	Enlarged liver and spleen. Marked weight loss
Case 6 White 68 Yrs. F	Carcinoma of rectum with metastases	5/ 4/60	64	38	4,100 cc.	4,012 cc.	Volume determination after 1,500 cc. of blood administered. Weight loss 9 Kg. Treated with nitrogen mustard
Case 7 Negro 43 Yrs. M	Carcinoma of floor of mouth	1/23/61	58	29	4,060 cc.	3,622 cc.	Weight loss 9 Kg. Chronically ill. After 1 unit of blood given, hematocrit level rose to 33

Table 3.—Group III: Miscellaneous

Patient Number Age, Sex, Race	Diagnosis	Date	Weight in Kg.	Hematocrit	Estimated Blood Volume	Calculated Blood Volume	Comment
Case 1 White 55 Yrs. F	Cirrhosis	7/11/60	47	30	3,055 cc.	2,475 cc.	Plasma value elevated as judged by hematocrit reading
Case 2 Negro 40 Yrs. F	Cirrhosis with portal hypertension	4/ 5/61	73	35	4,745 cc.	4,926 cc.	Portacaval shunt on day after admission. Portal pressure 460 mm. of water
Case 3 White 57 Yrs. F	Polycythemia	6/23/61	48	54	3,120 cc.	3,418 cc.	Slightly elevated blood volume determination
Case 4 White 49 Yrs. M	Polycythemia, mild pulmonary edema	9/15/60	75	55	4,875 cc.	6,050 cc.	Elevated blood volume determination. Phlebotomy with 1,000 cc. of blood withdrawn. Really a medical patient
Case 5 Negro 52 Yrs. M	Burn-40%	4/11/60 4/12/60 4/14/60 4/20/60	88 88 88 88	39 37 45 37	6,060 cc. 6,060 cc. 6,060 cc. 6,060 cc.	3,018 cc. 4,360 cc. 3,527 cc. 4,238 cc.	Between first and second blood volume determinations 2,000 cc. of blood and 900 cc. of plasma given; between second and third determinations 1,500 cc. of blood and 300 cc. of plasma given; then more blood and plasma given
Case 6 Negro	Carcinoma of rectum; ileal	2/22/61 3/16/61	45 34	44 41	2,925 cc.	3,861 cc.	Intestinal obstruction with perforation. Ileal fistula post-

crease beginning in the first trimester of pregnancy which runs to a high in some cases of 40 to 50 per cent of the total blood volume in the last trimester. A normal pregnancy then would increase the volume to approximately 8,000 cc.; add the fact that hepatosplenomegaly was present and a further increase would be expected.[8,9] Most of the marked elevation then reflects a physiologic state rather than overloading.

With regard to hypovolemia, where a low reading was obtained, to all intents and purposes it was an accurate value. In case 8 the patient suffered a gunshot wound of the abdomen. The first blood volume determination, obtained after 9,500 cc. of whole blood had been given, showed a deficit of approximately 1,000 cc., reflected by the typical state of shock. In the ensuing day 2 units of whole blood and 2 units of plasma brought the volume to a stable level. Case 13 is another example of true hypovolemia. The patient had bled from a gastric ulcer, and it took 1,500 cc. of blood following the volume determination to bring the hematocrit level to 32. In case 2 between the second and third volume determinations 1 unit of whole blood and 1 unit of packed cells were required to restore the volume to a nearly normal level. We could find no cases which exemplified a relative hypovolemia. The only manner in which this conceivably could occur is by giving unknowingly an increased dose of RISA.

Malnutrition (Group II)

The number of cases in this group (table 2) is not as large as in the previous one because it is extremely difficult to classify a patient as solely malnutritive. The patients placed in this category were on the surgical service for either therapy or diagnosis and were classified under malnutrition more on the basis of a by-product of the disease in question than as an evaluative measure. Practically none were operated upon. Naturally, there is some overlap of patients between Groups I and II. Certainly malnutrition is an integral part of many surgical diseases, as illustrated in table 1. In cases 6, 10, 18 and 22 specifically the patients showed marked evidence of malnutrition. Cognizance of the effects of malnutrition regarding blood volume proved most helpful to us in interpretation.

In considering loss in weight and its relation to blood volume, some standard form must and does exist. Pure starvation or malnutrition produces not a decreased blood volume but rather a relative increase for the weight under consideration and a relatively normal volume for the previous weight. The increase is concerned principally with the plasma component. Case 2 of this second group is a rather typical example. The patient lost 12 Kg., her weight decreasing from 57 Kg. to 45 Kg. On the basis of the reduced weight the blood volume should have been 2,995 cc. The calculated volume was 3,738 cc., a marked increase, and when the hematocrit level was only 31. A good deal of the excess then was on the basis of increased plasma volume. Based on the original "normal" weight when the volume would be estimated at 3,700 cc., our calculated volume closely approximated this, illustrating the point made. In case 5, the patient had a "large" weight loss and consequent relative increase in blood volume. In addition, an increased hematocrit level and the presence of splenomegaly further served to increase the volume.

An appropriate example of volume therapy to be used in malnutritive patients is illustrated by borrowing case 10 from Group I. The patient had lost considerable weight during the postoperative period with both hypoproteinemia and pelvic edema developing. The first blood volume determination showed a definite increase of some 1,200 cc. with a hematocrit level of 34. After judicious use, however, of several units of whole blood given in divided doses in addition to some serum albumin, the hematocrit level rose, the plasma volume decreased, and the edema subsided. This change was triggered to some extent undoubtedly by the cut-off mechanism of aldosterone with subsequent release of fluid plus the occupation of space by the mere presence of increased red cell mass. Giving large amounts of whole blood without benefit of a previous volume determination could have led to overloading of the circulation, particularly in a patient of this age.

Case 1 of Group II marks a subclassification of malnutrition. Here there was marked loss in weight with bone marrow depression. The calculated blood volume was 2,396 cc., almost 700 cc. below the estimated value of 3,055 cc. In the light of the foregoing illustration, this is not what one would expect from a 16 Kg. loss in weight, but the hematocrit level was only 24. The patient had a marked decrease in space-occupying or volume-producing red cells, more so than the average patient experiencing loss in weight, and thus the unexpected decline in volume. This particular patient's marrow depression

on the basis of involvement from carcinoma, undoubtedly one of the more frequent reasons for such a depression on a surgical service. In a case like this, judicious use of whole blood would be in order, whereas in case 10 of Group I either the whole blood in divided doses or packed red cells was the choice.

A further variant of malnutrition is loss in weight accompanied by a disease leading to further increase in blood volume. In case 5, a white man was known to have lost much weight in addition to having hemochromatosis. The blood volume increase was 1,350 cc., due to malnutrition, polycythemia with a hematocrit level of 50, and the marked hepatosplenomegaly which is of course associated with the hemochromatosis. Clinical improvement occurred after a phlebotomy.

In summary, this pathologic group has a basic norm from which several variants arise and must be reckoned with in interpretation. Of course, a person can have a fair degree of loss in weight and no volume change. Many times, particularly with our group of patients, it was difficult to ascertain the exact loss, but none the less the organism by some subtle change in volume control satisfactorily adjusts to the change in a normal fashion. Usually this occurs with loss in weight over a prolonged period, but may do so occasionally over the short term.

Miscellaneous (Group III)

This small group (table 3) was classified in this manner because the patients had a variety of diseases and were not necessarily malnourished, and also because miscellaneous seemed to be the only place where they could be suitably situated. Broadly speaking, we subclassified them into (1) diseases associated with increased blood volumes and (2) diseases associated with diminished volumes.

In the first subgroup there were two cases of cirrhosis. In case 1 a decline in volume of some 600 cc. in a measure could be attributed to the decline in red cell mass. On the other hand, in case 2, in which a known portal hypertension of 460 mm. of water was present, there was an increase in volume of 200 cc. This difference is of no real significance; as we stated earlier, a variation within this range was rather to be expected. Though these volumes are unimpressive, it is clear that in both cases a relative excess of plasma volume existed. Under certain circumstances[10] this is also to be expected. Polycythemia is associated with an increase in red cell mass which, in turn, occupies space or volume. We can then expect in many cases that the blood volume may be increased. A mild increase occurred in case 3 and a marked increase in case 4. In case 4 the factor of congestive failure had to be reckoned with, though it was not pronounced. With polycythemia there may be some increase in plasma volume also.

Two cases, one of a burn (case 5) and one of an ileal fistula (case 6), comprise the second subgroup. As will be discussed in succeeding paragraphs, a decreased volume is the rule with a burn. Plasma and other extracellular fluid modalities are being constantly lost. In case 5 in spite of large amounts of whole blood and plasma the volume did not even approach the so-called normal estimated volume. An ileal fistula such as occurred in case 6 would be expected to have an associated decreased volume, because of marked extracellular fluid contraction. Here there were two factors mitigating against the decrease, (1) the intensive effort made to supply the fluids, electrolytes, and proteins lost through the fistula, and probably even more important (2) the rapid loss in weight with attendant changes described under malnutrition.

Discussion

Blood volume consists of the amount of plasma and red cell mass within the confines of the vascular system; it must be thought of as a static figure rather than a dynamic phase of body physiology. Red cell mass is a relatively constant figure because there is no ready exchange across the capillary membrane, barring an actual break in continuity. On the other hand, plasma volume is constantly changing for several reasons. First, plasma is a division of the extracellular fluid in conjunction with the interstitial fluid. Between the two by means of the capillary membrane there is a constant exchange of water, electrolytes, metabolites and products for anabolic growth. Further, the interstitial fluid surrounds the intracellular phase of the body composition, and to a great degree, changes or needs of this phase are taken care of by the interstitial fluid, an ultra filtrate of plasma, which in turn is reflected in the plasma component. Painter, Holmes and Gregersen[11] showed in their experiments on dehydration that this is true. Dogs dehydrated rapidly by means of diuretics showed that most of the loss in weight was reflected in the loss of extracellular fluid. Dogs dehydrated by withholding food and water for a number of days showed

that a great deal of the loss in weight came from the intracellular water. It is obvious then how one phase influences another and how one phase is dependent on another. For these reasons, a blood volume is considered dynamic.

With these facts in mind, we must now proceed to a method by which an estimated "normal" volume might be calculated. It has been adequately shown through various methods[12] that approximately 6.5 to 7 per cent of the body weight in kilograms expressed as cubic centimeters is an acceptable standard for a normal person. For females, who have a larger amount of fat and consequently less blood volume, the volume is calculated at 6.5 per cent of body weight, while for males, who have a larger amount of lean tissue and hence a greater blood volume, it is calculated at 7 per cent. Occasionally extremes must be taken into consideration; for extremely obese patients the volume is sometimes calculated at 6 per cent while for well trained athletes, who have so much lean body mass, it must be calculated at 7.5 per cent. Another method of estimation which is acceptable is the number of cubic centimeters per pound of body weight. In fact, at the Jacksonville Blood Bank normal blood volume is considered to be 73 cc. plus or minus 5 cc.

A normal blood volume varies over any given period. Inkley, Brooks and Krieger[5] measured blood volumes in the same persons at weekly intervals and found variations up to several hundred cubic centimeters for the same person. Gregersen and Rawson[1] pointed out that a normal volume will also vary with the season, altitude, activity, and other factors. These facts are important when one is interpreting blood volume determinations, for a change of several hundred cubic centimeters is the rule and should in no way be suspect with regard to extremes of clinical pathology. Estimation of normal volume is important because this figure may be compared with a volume determination obtained in a particular clinical situation and a rational significance attached to it.

Noting that normal volume varies and that it is influenced by other fluid modalities as well as by the function of bone marrow, one may well ask why bother to ascertain blood volumes at all. The reason is that this test is another relatively accurate parameter of clinical balance that helps guide the physician to his ultimate goal, cure of the patient. A consideration of the packed cell volume (hematocrit value) may provide clarification. If a patient of advanced years with intestinal obstruction (small bowel) of several days duration, having had little vomiting but marked distention, is admitted with a hematocrit reading of 42, one might conclude that the volume on that basis alone is satisfactory. If a blood volume determination is obtained, there would be a marked diminution of plasma volume due to sequestration of extracellular fluid into the intestinal lumen. Earlier in the paper we mentioned that plasma is a division of the extracellular phase; thus the markedly decreased blood volume becomes obvious and explains the rapid pulse and decline in blood pressure which the physician may find in this theoretical patient. Further, Painter, Holmes and Gregersen[11] pointed out in their studies that hematocrit changes are utterly misleading as an index of volume reduction. There is no better clinical example of increased hematocrit value in the face of a fallen total volume than case 5 of Group III—a burn. At no time despite adequate hematocrit levels did the volume approach normal. Volume deficit was due, of course, to tremendous capillary permeability with loss of extracellular fluid and proteins and some red cell destruction. Large amounts of blood and plasma given to the patient failed to lower markedly the hematocrit level. This same phenomenon of extracellular fluid loss with increased hematocrit level also may be seen in cases of peritonitis, portal thrombosis, and severe pulmonary edema.

While a hematocrit value may be misleading, vital signs in selected cases may also be, but can be clarified by the use of blood volume determination. Case 5 in Group I is an example. While the volume determination was not needed for diagnosis and in fact, treatment was instituted prior to obtaining it, this information nevertheless confirmed the diagnosis. The patient's pressure began to decline during the operative procedure and was associated with a rapid pulse. While ordinarily this decline would indicate "shock," on a hypovolemic basis, a central mechanism could be involved. This proved to be so. Injudicious use of preoperative transfusions had overloaded the blood vascular system and caused development of congestive heart failure. Determination of volume was not needed to confirm the diagnosis; yet in a questionable case it may prove to be a life-saving measure when delineating true hypervolemia.

On the other hand, blood volume determinations cannot always be taken at face value. We formulated a subgroup in the evaluation section known as relative hypervolemia. The person un-

familiar with blood volumes would express concern because of overloading of the blood vascular system of the patient. In cases 9 and 23 of Group I there were markedly increased volumes in the face of a rapid pulse and lowered hematocrit level. Values such as these are obtained principally for two reasons. First, in a patient who is bleeding fairly actively the radioactive albumin is leaking out faster than it can be properly equilibrated; hence when the patient's sample is evaluated in the deep well chamber, the count will be markedly decreased. This count is the denominator in our formula, given under methods. It is reduced, and the result will be falsely increased. Secondly, if a patient is receiving blood rapidly as in case 23, a dilution factor occurs. The rapidity of administration dilutes the radioactive material causing again a decrease in the denominator and consequently another falsely high volume. Blood volume is only an auxiliary laboratory test in the care of the patient. If it does not agree with the clinical situation and cannot be explained on an adequate pathophysiologic basis, the physician is obliged to treat the patient on his clinical judgment, as was done in these two cases. Blood volume determinations in acutely bleeding patients are not reliable.

As pointed out earlier, malnutrition is a fairly frequent finding on a surgical service. As a rule it is associated with malignant disease and is either on an obstructive basis such as esophageal carcinoma or on the basis of widespread visceral metastasis sapping the vitality of the organism. The usual remark when a patient in such a condition is seen on rounds is, "He's lost a lot of weight; give him a couple of bottles of blood to pick him up before operation." This may be done, and then the surgeon wonders why pulmonary edema develops on the operating table. When a patient begins to lose weight, the fat content first breaks down, followed shortly by the lean tissue mass. These both contain large amounts of water, the fat being electrolyte-free but the lean tissue containing potassium. Energy of the organism declines, and red cell production somewhat decreases. In the wake of this process body volume begins to decline, and the extracellular compartment dilutes the sodium content to the extent that the patient becomes hyponatremic. This state in turn triggers the output of aldosterone, an antidiuretic hormone which causes a retention of sodium which in turn causes more fluid to be retained, so that proper osmolarity is affected. The patient, therefore, has lost much weight, has retained excess body water, and has an increased plasma volume but a reduced total volume in comparison to his normal weight. As Moore[6] aptly stated, "The chassis shrinks about the engine."

A malnourished patient, if he is properly prepared for surgery, should be given packed red cells as he needs red cell mass and not plasma volume. By giving packed cells an increase in volume is obtained, the volume regulator is "shut down," the output of antidiuretic hormone is reduced, and the patient begins to assume a more normal composition. Peden, Maxwell, Ohin and Mayer[12] in their excellent review of preoperative transfusion also pointed out this need. If packed cells are not available, whole blood transfusions should be given far enough apart to allow for the proper equilibration of plasma. We pointed out earlier that a concomitant decline in marrow production is sometimes associated with malnutrition, and in such cases the entire volume will be low, even for the newly calculated weight. In these instances one does not have to worry about overloading the blood vascular system to the same degree.

Normal responses of the body in regard to physiologic change also contribute to change in blood volume. Pregnancy offers the prime example. Beginning with the first weeks of gestation there is an increase in the total blood volume gradually progressing until parturition. Following this event there is a rapid decline in volume, principally due to the plasma loss. Caton and his associates,[7] measuring volumes in patients from one week gestation until the last trimester found that by the end of pregnancy a rise of 40 to 50 per cent over the original starting volume occurs. Statzer[13] also measured blood volumes in pregnant females and found a similar rise. This particular phenomenon was of interest to us because we had a patient with gastrointestinal bleeding who was eight months pregnant at the time the blood volume was obtained, as mentioned earlier. One, therefore, must be aware of normal changes in the interpretation of blood volume.

Other conditions will increase blood volume. Because of the ever increasing number of elderly persons undergoing surgery, an important disease entity to the surgeon is congestive heart failure. It is well agreed that most patients in frank failure will have an increase in total volume. While this is contributed to, to a degree, by red cells, for the most part it is due to plasma. Gunton and Paul[11] showed that as recovery from frank

heart failure occurred, there was a reduction in plasma volume and a rise in the hematocrit level. The degree of edema which the patient with congestive heart failure has is no index to the increase in plasma volume. Funkhouser, Pritchard and Littell[15] showed that while plasma volume is generally increased in congestive heart failure, the degree is dependent on the gain in weight of the patient, in regard to edema formation and extent of tissue wasting. Because a patient has congestive heart failure does not unequivocably mean that he will have an elevated volume. In case 23 of Group I there were many variables; the patient had some degree of congestive heart failure which could have accounted for part of the rise in volume. There is evidence that increased venous distention triggers an outpouring of aldosterone, with its attendant cycle.[16]

In a similar vein, cirrhosis, by complications, or associated with other diseases of a surgical nature, is not infrequently encountered on the surgical service at our institution. The disease in itself complicates matters, but even more germane to this discussion, it may be associated with elevated blood volumes principally in the plasma component. Eisenberg,[10] in studying blood volumes in patients with cirrhosis, noted an increase in plasma volume, particularly when increased portal pressure or cyanosis was present.

When cyanosis was present, there was some increase also in red cell volume due probably to anoxia. In other cases where these two complications were not present, there was generally no increase in volume. The mechanism here, as in congestive heart failure, is not clear, but perhaps the increased outpouring of aldosterone due to increased venous pressure may play a part. With ascites it is known that the production of aldosterone is increased, but in Eisenberg's study[10] ascites did not influence the volume to any great degree.

Splenomegaly in itself causes an increase in total blood volume.[8,9,17] As repeatedly pointed out in this paper, more than one aspect of a patient is to be considered. In case 11 of Group I a large increase in volume occurred on the basis of pregnancy, but also a splenomegaly was present to increase it further. In case 5 of Group II, in addition to malnutrition, splenomegaly contributed to the increased volume. It was stressed by Rothschild, Bauman, Yalow and Berson[8] that one of the foremost reasons for increased volume with splenomegaly is the increased mass of red blood cells within the spleen, changing the known ratio of total body hematocrit level to peripheral hematocrit level and hence an increased volume.

Polycythemia by virtue of the increased red cell mass causes an increase in volume, as was shown in the series of Chaplin, Mollison and Vetter.[17] In addition, it is noteworthy that both leukemia and lymphosarcoma, even in the absence of anemia, may be associated with higher plasma volume.[8]

Not all patients, despite acute and chronic illness, will have changes in volume. Normal volume in an ill patient with no previous therapy simply means that no radical change has taken place as yet. If "volume" therapy has been administered and a normal reading is obtained, the clinician may then congratulate himself on his excellent acumen.

There are many factors affecting blood volume, ranging from physiologic response to diseases of blood-forming organs, to technical errors, and to visceral disease. If the physician is aware of these changes, he is better able to appreciate his results and apply them accordingly. To reiterate, blood volume, while important, is only a laboratory test and must be considered as such. It must be considered in terms of multiplicity, and any disagreement between those results and the clinical judgment of the physician should be resolved in favor of the clinical judgment.

Summary

An analysis of 64 blood volume determinations performed on 49 patients on a surgical service is presented.

The blood volume was estimated by utilizing radio-iodinated serum albumin (RISA), and the method used is presented.

The patients were placed in three groups: (1) evaluation, (2) malnutrition, and (3) miscellaneous. A discussion pointing out variations in the interpretation of results in the different groups and in certain diseases which in themselves changed blood volume is presented.

It is concluded that blood volume determination is only a laboratory procedure and should not supplant clinical judgment.

We would like to acknowledge that Mrs. Lucille Thaxton ran and calculated all the blood volumes used in this series and we wish to express our sincere appreciation.

References are available from the authors or from The Journal.

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Surgical Aspects of Emphysema

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TAMPA

The value of surgery in the management of certain types of pulmonary emphysema has been recognized in recent years. The surgical aspects of emphysema encompass supportive as well as definitive forms of treatment. Bronchoscopy and tracheostomy have long been recognized as valuable aids to the medical management of this disease. Bronchoscopy allows the aspiration of bronchial secretions and instillation of local medications. Tracheostomy has the added advantages of allowing more frequent and repeated aspirations and instillations of medication with less discomfort and expense. Also, the respiratory dead space is decreased, and in the case of the comatose hypercapneic patient, a mechanical respirator can readily be connected to the tracheostomy tube. Because of the inconvenience of the tube and loss of phonation, tracheostomy is usually reserved for the far advanced or critically ill patient. More recently, Rockey, Blazsik, Thompson and Virabutr[1] advocated the use of tracheal fenestration to avoid these inconveniences. Wolcott, Kiernan, Sigel and Baum[2] questioned the advantages of tracheal fenestration in that it does not fulfill all of the functions of a tracheal stoma, namely, the reduction of respiratory dead space and the diminution in collapse of the bronchi during expiration. The latter point is certainly open to question with either procedure.

Classification

From the surgical aspect, emphysema may be classified into primary, secondary and congenital types. The congenital type is localized, but the primary and secondary types may be generalized or localized. Primary obstructive pulmonary emphysema is a crippling and eventually fatal disease. Its incidence is as common as that of rheumatoid arthritis, and it appears to be increasing in frequency as rapidly as bronchogenic carcinoma.[3] The generalized form of the disease invariably involves some areas of the lung more than others. This difference is readily seen at surgery or at the autopsy table. Because of this discrepancy and the fact that the peripheral areas are more involved, Brantigan, Mueller and Kress,[4,5] Miller[6] and others thought that resection of the so-called "dead spaces" of lung tissue would improve the ability of the lesser involved areas of the lung to function more efficiently. Only the most involved areas are resected, and this operation never amounts to a lobectomy in order to avoid resection of lesser involved tissue. Brantigan and his associates[4,5] also advocated lung denervation contending that this decreases cough, but they readily admitted that the function of the autonomic nerves to the lung is not clearly understood.

Bedell,[7] on the other hand, advised against any resection in the generalized form of the disease, claiming that removal of one section results in overdistention of another section and is of no benefit to the patient. Although most thoracic surgeons are reluctant to approach pulmonary emphysema as radically as Brantigan because of the high mortality rate[5] and continued progression of the disease, there is no doubt that some patients may be helped by resection. This result is seen in the treatment of complications of generalized pulmonary emphysema when the surgeon's hand may be forced.

Case 1 illustrates the dramatic results of resectional surgery in a patient with generalized pulmonary emphysema on whom we would not have operated had a complication not developed.

Report of Cases

Case 1.—A 51 year old married white man was seen first in November 1957, at which time he was complaining of dyspnea on exertion of 14 months' duration precipitated by a spontaneous pneumothorax. Dyspnea had progressed rather rapidly over the next two years and was accompanied by loss in weight. In November 1959 he was hospitalized with a spontaneous pneumothorax (fig. 1a). He was successfully treated with catheter drainage and suction and discharged 11 days later. Spontaneous pneumothorax recurred twice in the next 30 days, and a bronchopleural fistula developed. The patient was markedly dyspneic. On Jan. 13, 1960, an open thoracotomy with resection of multiple blebs of the upper and lower lobes of the left lung, pleurectomy and tracheostomy were performed. The patient was discharged from the hospital 16 days later markedly improved (fig. 1b). At the time of surgery he weighed 113 pounds and currently weighs 165 pounds. His breathing is markedly improved, and he lives comfortably if he does no strenuous work whereas preoperatively he was dyspneic at rest. The importance of a tracheostomy cannot be over-

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emphasized in the postoperative management of the patient with far advanced pulmonary emphysema. The tracheostomy is kept open at least until air leaks have sealed and secretions are no longer a problem.

Surgery in case 2 was also precipitated by the development of a pneumothorax.

Case 2.—A 66 year old married white man was admitted to the hospital on Dec. 15, 1960 with a history of acute onset of dyspnea following a violent paroxysm of coughing 11 days previously. A roentgenogram of the chest (fig. 2a) revealed a pneumothorax on the right side, large bullae at the base of the right lung and apical blebs. The patient had had three attacks of pain in the right side of the chest and shortness of breath in the past 12 years, but had never been subjected to roentgen examination. An open thoracotomy was performed 48 hours after admission. Two large bullae on the anterior and superior segments of the lower lobe of the right lung were resected following which the apical blebs were resected and an apical pleurectomy performed. The postoperative course was uncomplicated, and the patient has had rather dramatic improvement in pulmonary function (fig. 2b) and has gained in weight.

The simplest procedure in this situation would have been to insert a catheter in the chest and maintain negative suction. On the other hand, this procedure would not have resulted in as dramatic an improvement in the pulmonary function, for the patient admittedly breathes better now than he has in the past 10 years. We also believe that the pleurectomy has lessened the likelihood of recurrent pneumothorax.

We have not personally performed or advocated elective resectional surgery for patients with generalized obstructive pulmonary emphysema because we do not think that we are retarding the progress of the disease, the improvement is only temporary and the mortality rate is high.[5] Conversely, one does not know the prognosis in this disease in regard to duration of life, and perhaps we should take a more aggressive surgical approach toward some of the patients in the hope of at least giving them palliation.

The most gratifying type of emphysema for the surgeon to treat is the so-called localized bullous emphysema. This is in essence a localized form of primary obstructive pulmonary emphysema. It usually involves one or both apices, but may involve other areas of the lung as well. The remainder of the lung may be normal, or varying degrees of pulmonary emphysema may be present. In these areas of localized bullous emphysema bronchogenic carcinoma is more prone to develop.[3] The cases that have given universally good results following resection have been those with localized bullous emphysema, but with the rest of the lung appearing normal.[3,9]



Fig. 1a.—Bilateral pulmonary emphysema with spontaneous pneumothorax on the left side. b.—Postoperative roentgenogram (six months) following resection of multiple blebs of the upper and lower lobes of the left lung.

Case 3.—A 44 year old married white man was first seen in July, 1957, complaining of dyspnea on exertion of three years' duration with gradual progression of symptoms. A roentgenogram of the chest revealed bilateral bullous emphysema localized to the upper lobes (fig. 3a). On Jan. 11, 1959, the patient was operated on, and the entire upper lobe of the right lung was removed because of extensive involvement. The middle lobe was normal, but it was necessary to resect an area of emphysematous

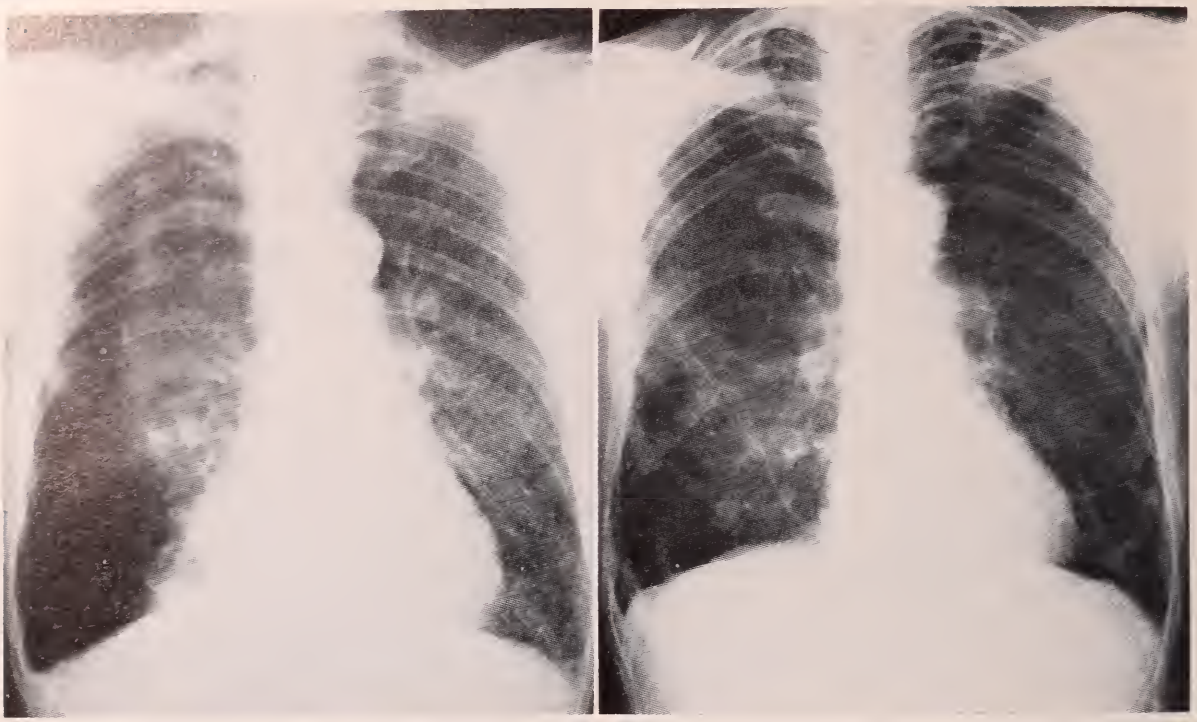


Fig. 2a.—Admission roentgenogram showing bullous emphysema and pneumothorax on the right side. b.—Postoperative roentgenogram (three months) following resection of bullae of the lower lobe and apical blebs.

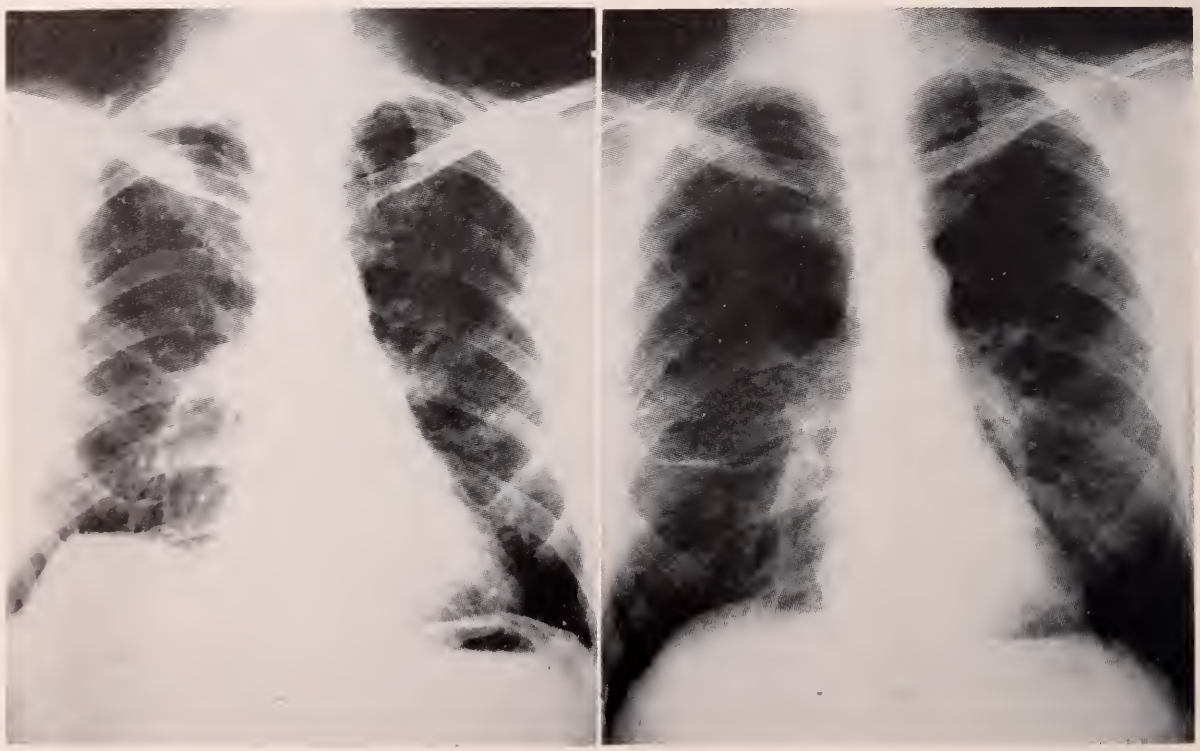


Fig. 3a.—Bilateral bullous emphysema localized to the upper lobes in a 44 year old white man. b.—Postoperative roentgenogram following bilateral resection, May 1961.

blebs in the superior segment of the lower lobe of the right lung. The postoperative course was uncomplicated. The patient was readmitted to the hospital approximately a year later (Feb. 21, 1960), and on the following day an area of localized bullous emphysema involving the apex of the upper lobe of the left lung was resected. The largest cystic area measured 14 cm. in diameter, but there were five other smaller cysts. The remainder of the left lung appeared normal. The patient has done well since surgery and currently is running a feed bag business necessitating a fair amount of physical labor. A roentgenogram of the chest made in May 1961 is shown in figure 3b.

Secondary pulmonary emphysema is seen superimposed on a generalized pre-existing lung disease such as bronchiectasis, tuberculosis, silicosis or sarcoidosis. Resectional surgery is not indicated



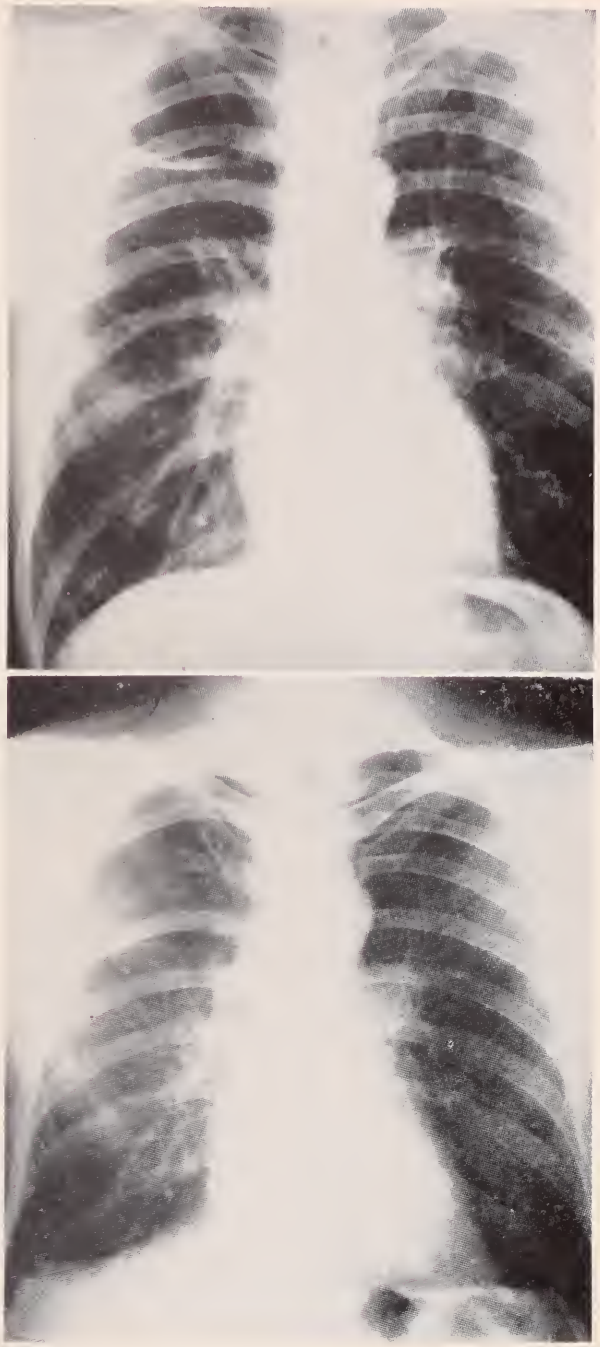


Fig. 4a.—Tension cyst of the upper lobe of the right lung with air fluid level. b.—Roentgenogram made three years previously (1956). c.—Postoperative roentgenogram.

in the treatment of the emphysema per se. Rarely one sees localized secondary pulmonary emphysema in association with a bronchial cyst or mucocele,[10] and surgery is indicated. This condition is exemplified in case 4.

Case 4.—A 51 year old white man was first seen in September 1959, acutely ill with daily spiking temperature ranging from 104 to 105 F. Roentgen examination revealed a large tension cyst in the upper lobe of the right lung (fig. 4a). A roentgenogram made in 1956 (fig. 4b) was available for comparison, which revealed a much smaller cyst in the apex of this lung. The patient had been advised against pulmonary surgery at that time by his internist. At operation on September 25, a large thick-walled tension cyst of the upper lobe occupying at least half of the right side of the thorax was found. The surprising finding was an associated secondary localized type of emphysema involving the superior segment of the lower lobe of the right lung. This area measured approximately 10 cm. in diameter. Both areas were resected. Microscopic studies revealed the large thick-walled cyst to be lined with mesothelium while the lower lobe lesion was the picture of emphysema. The patient has done well since surgery. Prior to operation he had been dyspneic on exertion and now has normal pulmonary function. A postoperative roentgenogram is shown in fig. 4c.

Congenital pulmonary emphysema, although still relatively uncommon, is being recognized with increasing frequency. It is almost invariably localized to a lobe or segment and rarely to an entire lung. In some instances it can be classified as secondary emphysema in that partial bronchial obstruction associated with infection, atelectasis, tumor or aspirated material can be demonstrated. Other obstructive factors sometimes incriminated are compression of a thin-walled bronchus by an aberrant vein, localized bronchial chondromalacia, patent ductus arteriosus and a fold of mucous membrane producing a valvelike mechanism in the bronchus. On other occasions no site of obstruction can be identified.[11-13] Surgery is almost always indicated in this type of disease, and in infants it may be mandatory for survival.[13,14]

Case 5.—A 28 year old housewife with localized pulmonary emphysema, most likely of congenital origin, at the age of four years had pneumonia on the left side and subsequently had a drainage tube in the left lower posterior portion of the chest. Except for frequent respiratory infections she was reasonably well until six years prior to first consulting us in November 1957 (fig.

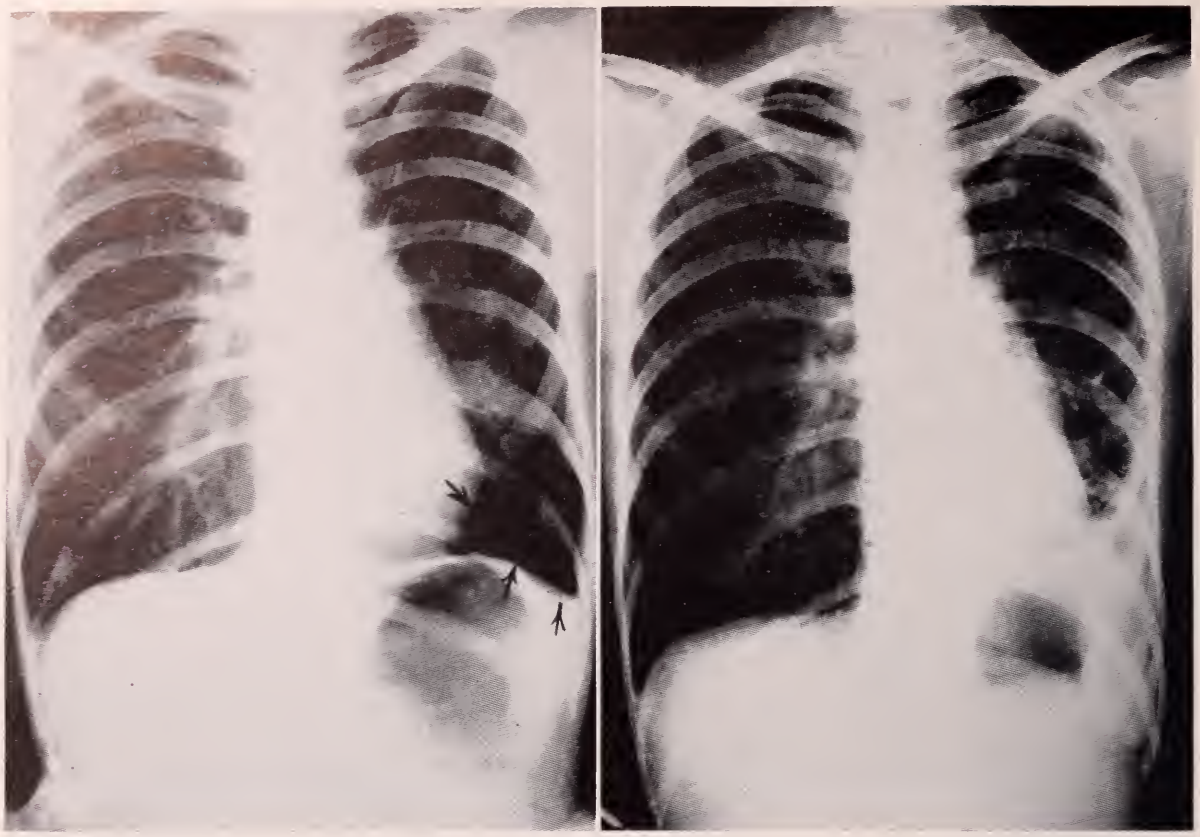


Fig. 5a.—Congenital pulmonary emphysema localized to the lower lobe and lingula of the left lung in a 28 year old white woman. b.—Postoperative roentgenogram.

5a). Beginning at that time she had had recurrent bouts of pneumonia, chronic cough, occasional pain in the left side of the chest and gradual loss in weight from a normal weight of 105 pounds to 90 pounds. Numerous sputum examinations in the past had been negative for acid-fast bacilli.

On November 21, the patient was operated on because of the changes in the lower portion of the left lung and was found to have a localized emphysema involving the entire lower lobe and the lingula. The remainder of the lung appeared normal. The lower lobe and lingula were resected, and microscopic study revealed typical emphysematous changes with loss of alveolar septa plus severe chronic bronchiolitis. Following the operation the patient gained in weight and became completely asymptomatic. A postoperative roentgenogram is shown in figure 5b.

Summary

In summary, the importance of bronchoscopy and tracheostomy as adjunctive measures in the treatment of pulmonary emphysema has long been recognized. Tracheal fenestration has not been as advantageous as originally hoped, but it may be a worth while procedure in selected cases.

Resectional surgery is of definite value in the treatment of localized bullous emphysema, congenital localized emphysema, and secondary emphysema with obstruction due to a lung cyst or mucocele.

Resectional surgery has not been widely accepted in the treatment of advanced generalized primary obstructive pulmonary emphysema. Occasionally surgery becomes mandatory in this disease because of the development of pneumothorax with a bronchopleural fistula. Although the results are only palliative, they may be dramatic and life-saving.

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One Davis Boulevard.

Inorganic Chemistry in Electrolyte Balance

George F. Schmitt, M.D.
MIAMI

Basic Chemistry

In order to understand the basic mechanisms of fluid balance, one must first study certain fundamentals of inorganic chemistry.

Atomic and Molecular Weights

Chemists speak of atomic weights. Is the actual weight of an atom known? The answer is no. The weights that the chemists use are relative—not actual.

The hydrogen atom was first used as a standard, but since oxygen combines with so many more substances, it has supplanted hydrogen. The atomic weight of oxygen has been assigned an arbitrary figure of 16. By this standard, sulfur has an atomic weight of 32; that is, the sulfur atom is twice as heavy as oxygen. A number of substances combine as integer multiples of oxygen. The atomic weights of certain important substances are:

Sodium	23
Potassium	39
Calcium	40
Chloride	35

The gram molecular weight (mole) is the number of grams of a substance that is equal to its molecular weight.

Solutions

When a solid and a liquid are so intimately mixed that separate particles can no longer be seen, the result is a solution.

A molar solution contains the gram molecular weight of a solution in sufficient water to bring the total solution to one liter.

Ionization

Water itself has very low electrical conductivity. Many aqueous solutions of organic substances (sugar, glycerol) are also poor conductors. Other solutions, however, conduct current well. These include solutions of most acids, bases, and salts.

What is the explanation?

In 1887, Arrhenius formulated the theory of ionization. The chief postulates are:

1. When acids, bases, and salts are dissolved in water, some of the molecules immediately dissociate into particles called ions.

2. Ions are charged with electricity. Those from one part of the molecule are positive; those from the other are negative. The electrical charges are in units according to the valence. There is no excess of either positive or negative ions dissociating from each molecule of an electrolyte. There must be an equal number of positive and negative charges.

3. In an electrolytic cell, the electrode where the current enters is positive and is called the anode. It attracts negatively charged ions termed anions. The electrode when the current leaves is negative, and is called the cathode. It attracts the positively charged ions designated cations.

4. The only difference between an atom and an ion is the electrical charge.

Anions

The chief anions are bicarbonate, chloride and phosphate.

Cations

The principal cations are sodium, potassium, calcium and magnesium.

Valence

If there were no orderly way in which the elements combined, one would be faced with the horrendous task of memorizing the formulae of many thousands of compounds. Fortunately, there is order and each element has a definite combining power called valence, which determines the number of other atoms with which an element can combine.

The principal monovalent atoms are sodium, potassium, ammonium chloride, hydroxyl and bicarbonate.

The divalent atoms are calcium and oxygen.

Assistant Clinical Professor of Pharmacology, University of Miami School of Medicine.

The Milliequivalent

Until recent years, it has been the custom to express the concentration of electrolytes in milligrams per 100 cubic centimeters; that is, in terms of absolute weight of the substances which react together not by absolute weight, but by equivalent weights. Thus, one equivalent weight of sodium (23 Gm.) reacts with one equivalent weight of chlorine (35.5 Gm.) to form sodium chloride (58.5 Gm.) If, instead of a system based on absolute weights, a unit of measurement is used which neglects these differences in absolute weight, and expresses the concentration of electrolytes in terms of equivalent weights, the information gives a more accurate picture of the chemical structure of the body fluids.

If one compares the power of a locomotive and an airplane, one should not express the power in absolute weights of each, but rather in the horsepower. For example, a certain diesel locomotive weighs 230,000 pounds, but only develops 1,500 horsepower, while an airplane weighs 45,000 pounds, but has 4,800 horsepower.

The milliequivalent, then, is the term used to express the "horsepower" of the electrolytes.

Definition

The milliequivalent (mEq.) is the weight of an element of ion which will combine with or be chemically equivalent to 1/1000 Gm. of hydrogen.

Conversion of Milligrams to Milliequivalents

Since in many laboratories electrolytes are reported in milligrams rather than milliequivalents, one must be able to convert when necessary. Conversion is accomplished by the following formula:

$$\text{mEq./L} = \frac{\text{Mg./100 ml. x 10 x valence}}{\text{atomic weight}}$$

The significance of all the terms used in the formula has been explained except that of the number 10. Since the milligrams are reported in terms of 100 cubic centimeters (1/10 of a liter), and milliequivalents are reported in terms of a liter, it is necessary to multiply milligrams by 10.

Conversion Factors

If one had to use this formula every time milligrams had to be converted to milliequivalents, the process would be unwieldy. Fortunately, conversion factors for each ion have been developed. To change milligrams to milliequivalents, merely multiply the weight by the factors given here and the result is milliequivalents.

These factors are:

Sodium	.435
Potassium	.256
Chloride	.282
HCO_3	(Vol. % x 0.45)
Calcium	.50

Normals

Almost all physicians know the normals of elements expressed in milligrams. Some, however, may be unfamiliar with the normals designated in milliequivalents.

The normals are:

Element	Range	Average
Sodium	130-145	142
Potassium	4-5.5	5
Chloride	100-110	103
HCO_3	25-30	27
Calcium	4.5-5.5	5

Weights and Milliequivalents Compared

The significance of the feasibility of using milliequivalents instead of weights in measuring electrolytes is most expressively presented in the following table:

Body Electrolytes

Electrolyte	Milligrams	Milliequivalents
Cations (base)		
Sodium	326	142
Potassium	20	5
Calcium	10	5
Magnesium	24	2
Total base	358	154
Anions (acid)		
Bicarbonate	60.5	27
Chloride	365.7	103
Phosphate	3.4	2
Sulfate	1.6	1
Organic acid	17.5	5
Proteinate	6500	16
Total acid	6948.7	154

From this table, three points are to be noted: (1) the great disparity between weight and milliequivalent (horsepower), (2) the great preponderance by weight of the acid radicals and (3) the sum total of the anions and cations, is equal. The last statement implies that, in health, the body is electrolytically stable, which is, of course, what one should expect.

Osmosis

If red blood cells are placed in pure water, they swell and burst. This is the result of the fact that the cell wall is permeable to water, but not to some of the solutes. In an effort to reach

equilibrium (equality of water pressure) between the two liquids, water enters the cell.

Imagine a thin skin secured over the end of a thistle tube and the bulb filled with salt solution. The end of the bulb is immersed in distilled water. In a few hours, the water will rise in the tube. The more concentrated solution has become diluted with the addition of water. Note that the balance of movement is always from the place of lesser concentration to the greater.

Definition

Technically stated, the hydrostatic pressure which is necessary to bring the solution into equilibrium with the pure solvent when the two are separated by a differentially permeable membrane, is a measure of what is called the osmotic pressure of the solution. It is the "drawing" power of a solution.

Units of Measure

We have seen that the milliequivalent is the unit of measure of the chemical activity of an electrolyte. It is based on the number of ionic particles in a solution. The osmol is the unit of measure of the osmotic activity of an electrolyte solution, that is, the amount of work that dissolved particles can do drawing fluid from one compartment to the other.

Definition

An osmol is the osmotic pressure produced when one gram molecular weight of a substance is dissolved in one liter of water. A milliosmol is 1/1000 of an osmol.

Derivation

The formula for deriving milliosmols per liter is as follows:

$$\text{M Osm/1} = \frac{\text{mg./100 cc. x 10}}{\text{atomic weight}}$$

Milliequivalents and Milliosmols Compared

As stated, the former is a measure of electrical activity, the latter for osmotic activity. Since almost all the elements are monovalent (carry only one electrical charge), the weight of each is the same. With polyvalent elements and radicals, however, the electrical charges are greater than their osmotic pressure.

Take a solution of magnesium sulfate, each ion of which is divalent and carries two electrical charges. Five particles have the chemical activity as a function of 20, but only an osmotic activity in the order of 10, which is the number of particles present.

The following table will make the relationship clear.

Milliequivalents

Mg ++	Mg ++	Mg ++	Mg ++	Mg ++
SO_4 — —	SO_4 — —	SO_4 — —	SO_4 — —	SO_4 — —

Electrical Charges — 20

Milliosmols

Mg	Mg	Mg	Mg	Mg
SO_4	SO_4	SO_4	SO_4	SO_4

Particles — 10

Milliequivalents

Na +	Na +	Na +	Na +	Na +
Cl —	Cl —	Cl —	Cl —	Cl —

Electrical Charges — 10

Milliosmols

Na	Na	Na	Na	Na
Cl	Cl	Cl	Cl	Cl

Particles — 10

It is important to remember that electrolytes not only maintain acid base and electrical balance, but also play a part in control of body water volume by establishing osmotic pressure.

Summary

The basic principles of inorganic chemistry for a clear understanding of the fundamentals of electrolyte balance are presented.

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VOLUME XLVIII
NUMBER 9

Use of a New Sulfonamide in Pediatrics

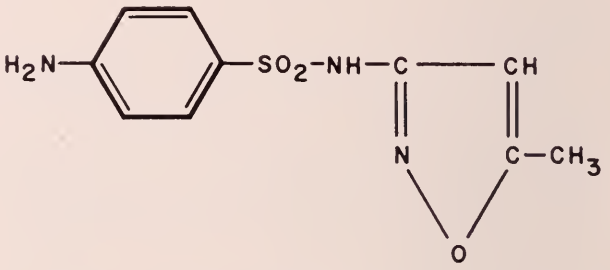
PHILIP J. CHASTAIN, M.D.
CORAL GABLES

Invasion of the upper respiratory tract by bacteria or viruses, even if usually self-limiting, occurs with sufficient frequency in infants and children to warrant keeping the young patient under observation until a cure is established. Diagnostic differentiation between bacterial and viral etiology is sometimes difficult, complicating the choice of appropriate medication. In some upper respiratory infections serious complications may occur unless the invading organism is eradicated. For these and other reasons, management of infections in the vulnerable respiratory passages is beset with clinical problems.

Chemotherapy, while eliminating many of these problems, presents its own complications. In treating children the wide spectrum antibiotics must be used with great discretion because of the severity of those side effects which occur in a small percentage of patients, because it is inadvisable to use these potent agents for relatively minor troubles and thus nullify their effectiveness for major crises later in life, and because the indiscriminate use of antibiotics has generated a grave public health problem. Not only may resistant strains of beta hemolytic Staphylococcus turn an acute condition into a persisting one, but it is the obvious duty of all doctors to help control the development and spread of those strains among the general population.[1]

Here the sulfonamides play a valuable role, since they represent a new line of attack against those bacterial forms likely to develop resistant strains. The newer agents have proved that they possess considerable bactericidal action, with a high index of effectiveness against Streptococcus infections,[2] and the gram-negative group in general. Some of the newer sulfonamides have now established themselves as highly effective bactericides with a minimum of toxicity.[3-5] Townsend and Borgstedt[6] used sulfadimethoxine* in nearly 700 patients with a variety of upper respiratory and gastrointestinal infections, finding it 90 per cent effective in this series.

Recently a new sulfonamide, closely related chemically to sulfisoxazole,* has been under investigation. This agent, Ro 4-2130 (Gantanol), is a methyl-isoxazole derivative of sulfanilamide, with a structure as follows:



During pharmacological study Gantanol proved its ability to attain more sustained blood levels than Gantrisin, reaching therapeutic levels in from four to six hours after administration, and maintaining effective concentration for 12 hours or more.[7] Early clinical trials indicated that this sulfonamide might prove effective in cases of resistance to other drugs. Braden, Colmore and Cummings[8] used Gantanol in 90 patients with beta hemolytic Streptococcus pharyngitis, and found after a 10 day course of medication that cultures were negative in 83 of the series. They considered the new sulfonamide a safe and highly effective treatment. Brandman and Engelberg[9] established that Gantanol attained therapeutic blood levels within two hours and maintained them up to 12 hours, following a single 2 Gm. dose. Their urinary studies showed a high rate of excretion.

The present study was directed toward the evaluation of Gantanol used alone and also in an adjunctive and prophylactic role with an antibiotic (plus ACTH in asthmatic cases). The intention was to appraise clinical response, patient acceptance, optimal dosage, and the effects, if any, on the kidneys, or other side reactions. A group of 162 children was treated with Gantanol during the 1960 spring epidemic of upper respiratory infections and related complications.

Materials and Methods

The patients in the study consisted of 77 males and 85 females, ranging in age from three weeks to 15 years. The age distribution was as follows:

*Madribon (sulfadimethoxine) and Gantrisin (sulfisoxazole) are trade names of Hoffman-La Roche Inc., Nutley, N. J.

0 — 6 months	13
7 — 12 months	10
13 months — 5 years	79
5 years — 10 years	50
10 years — 15 years	10
	162

The diagnoses are given in detail in table 1. Fifty-eight of the patients had uncomplicated upper respiratory infection; 66 had upper respiratory infection complicated by sinusitis, otitis media, and other ailments, and the remaining 38 had various diagnoses with no infection involving the upper respiratory tract.

Dosage of Gantanol was determined by the patient's weight, the amount with few exceptions running slightly under the recommended 25 mg./lb. Infants were usually given approximately 2 Gm. over a seven day period, children 13 months to five years from 3 to 5 Gm. a week, and older children about 7 Gm. per week. Most of the patients received medication in the form of a pediatric suspension, a teaspoonful representing half the daily dosage. A few patients were given tablets of 500 mg. each. Medication was in all cases begun with an immediate dose of the entire daily amount, followed by morning and evening doses of one half the daily amount during the period of therapy. The amount administered daily was 1 Gm. or less except in one patient, a boy of 13 with upper respiratory infection complicated by sinusitis and otitis media, who received 2 Gm. a day for 11 days.

In 77 cases Gantanol was used adjunctively with an antibiotic for periods ranging from two days to a week, following which Gantanol was used as the sole antibacterial. Combiotic was used in 70 cases; penicillin was administered in four cases, and Terramycin in three. In addition to an antibiotic, ACTH was used in 16 cases of asthmatic bronchitis, asthma, and sinobronchial syndrome.

Duration of Gantanol therapy was a week or less in approximately 70 per cent of the series, two weeks in 20 per cent, and three or four weeks in 10 per cent.

Urinalyses were done in 121 cases, as a rule after one week of Gantanol therapy, and in 26 instances a second test was made a week later. No bacteriological studies were made.

Results

The results of Gantanol therapy are summarized in table 1. In 150 of the 162 cases the clinical response was considered satisfactory, an over-all percentage of 92.5 good results was obtained in 81 of the 85 patients who received only Gantanol (95.3 per cent), and in 69 of the 77 patients receiving an antibiotic as well (89.6 per cent). It should be pointed out that the group receiving combined therapy included the more severe cases.

Patient acceptance of the medication was favorable, with one or two exceptions.

Uncomplicated upper respiratory infection generally cleared up in four to seven days; the sinusitis and asthma-complicated cases were more stubborn, and often required two to four weeks of medication before the patient was discharged as cured.

Fair or poor response occurred in the four cases of viral upper respiratory infection; in two cases of otitis media; in two cases of uncomplicated upper respiratory infection; and in single cases of sinusitis, upper respiratory infection plus sinusitis, upper respiratory infection plus asthma, upper respiratory infection plus otitis media, and Staphylococcus infection and boils.

Response to Gantanol therapy occurred in most of the patients in four or five days; only rarely did it take six or seven days for the drug to show positive effects.

The results of the urinalyses were negative except for traces of nonsulfa crystals in a fraction of the samples, and some albumin in the before-treatment sample of one patient suffering from repeated upper respiratory infections, as well as albumin and white blood corpuscles in the before-treatment samples in the three pyuria cases.

No side effects were observed in any of the patients receiving Gantanol therapy.

Summary

A series of 162 pediatric patients, most of whom suffered from upper respiratory infections with or without complications, received therapy with a new sulfonamide, Gantanol. Daily dosage of 1 Gm. twice a day was sufficient for most of the patients over five years of age, and response was noted as a rule within three or four days. In 85 cases Gantanol was the sole therapy, and in the other 77 cases it was used adjunctively with and following a brief course of medication with antibiotics, usually Combiotic. Although the series included several refractory cases, the results of Gantanol therapy were satisfactory in 150 (92.5 per cent). Approximately 70 per cent of the patients were discharged as cured after a week's

Table 1.—Results of Gantanol Therapy in 164 Pediatric Patients

Diagnosis	Number of Cases	Gantanol Alone			Gantanol and Antibiotics		
		Good	Fair	Poor	Good	Fair	Poor
Upper respiratory infection, uncomplicated	58	40			16	2	
Upper respiratory infection, sinusitis	24	15			9		
Sinusitis	8		1		7		
Upper respiratory infection, otitis media	20	11			8	1	
Otitis media	7	2		1	3		1
Upper respiratory infection, viral	4		1	1		1	1
Asthmatic bronchitis	8				8		
Upper respiratory infection, asthma	8	1			6		1
Upper respiratory infection, gastroenteritis	4	2			2		
Gastroenteritis	5	2			3		
Upper respiratory infection, pyuria	1				1		
Pyuria	2	2					
Upper respiratory infection, conjunctivitis	2	2					
Upper respiratory infection, vaginitis	1				1		
Upper respiratory infection, vulvitis	1	1					
Scarlet fever	2	1			1		
Sinobronchial syndrome	1				1		
Staphylococcus infection, boils	2				1		1
Upper respiratory infection, adenitis	1				1		
Bronchitis follow-up	1	1					
Streptococcus throat infection	1				1		
Tonsillitis	1	1					
Total	162	81	2	2	69	4	4

medication. There were no untoward side reactions, and patient acceptance was good.

An interesting aspect of this study was the fact that Gantanol alone was close in therapeutic effect to Gantanol used adjunctively to an antibiotic. The new sulfonamide is apparently effective in combating bacterial strains habitually encountered in respiratory tract infections. Though no bacteriological studies were made, the pediatrician is familiar with the spectrum of organisms implicated in upper respiratory infections among children. It was gratifying to find a singularly

nontoxic sulfonamide which apparently may be used instead of an antibiotic in a variety of upper respiratory infections. Viral forms of upper respiratory infection of course may elude both sulfonamides and antibiotics, and in the present series the four cases of upper respiratory infection suspected of being viral ended in one fair and one poor result in each group (Gantanol alone or Gantanol with an antibiotic). In the same way, there was one failure in each group under the diagnosis of otitis media. Possibly in these two cases the disease was of viral etiology; or the failure may have been due to the difficulty in obtaining therapeutic levels in the area of the ear because of its poor blood supply.

It would appear in order to recommend further investigation of Gantanol, either as adjunctive to antibiotics in certain cases, or used alone. Asthmatic cases, of course, would also require specific medication.

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103 Douglas Entrance.

Abstracts

Pregnancy Occurring in a Rudimentary Horn; Report of a Case. By John J. Fisher, M.D. Obst. & Gynec. 16:419-423 (Oct.) 1960.

A case is reported in which abdominal pregnancy occurred in a young white woman in a rudimentary uterine horn. Of particular interest were the demonstration of the usual rather marked discomfort which characterizes early abdominal pregnancy; the obtaining of the decidual cast of the uterus and the demonstration of transmigration of sperm from the ostium of the left tube through the abdominal cavity to the ostium of the right tube arising from the rudimentary horn. As is usual, positive diagnosis was made at the time of laparotomy.

Subdural Hematoma in Older Patients. By Irwin Perlmutter, M.D. J.A.M.A. 176:212-214 (April 22) 1961.

The problem of the clinical diagnosis of subdural hematoma is often considered so difficult that, at those clinics which have treated the greatest number of patients with craniocerebral trauma, diagnostic trephination has been commonplace. The abnormality most frequently encountered in elderly patients harboring this lesion is a deterioration of the state of responsiveness. Subdural hematoma in older persons is frequently an insidious lesion, and a patient who has been merely increasingly drowsy over a period of days may slip into irreversible coma to exitus, the nature of the illness never having been suspected. The author presents four cases which support this thesis and provide a basis for explaining the pathophysiological mechanism. He concludes that consideration of subdural hematoma as the cause of progressive drowsiness in elderly people is of great importance.

Enterogenous and Multiple Mesenteric Cysts. By Banning G. Lary, M.D., and Robert F. Mikell, M.D. Am. J. Dis. Child. 100:412-414 (Sept.) 1960.

Particularly in infancy, any rapidly enlarging abdominal mass warrants prompt diagnostic study. An unusual outcome of exploratory laparotomy in a five month old child, with convalescence, is here described. Cysts of the mesentry are rare occurrences, probably the rarest of all abdominal tumors. The authors report a case of enterogenous cyst with multiple cysts of the mesentery wherein pneumococcus abscess formed in one of the cysts. They were unable to find this occurrence previously reported in the literature.

President's Page

The Woman's Auxiliary

A drowning man probably never realizes how vital air is to him until he is going down for the third time. I suppose then he realizes that he has had it all his life but has never really appreciated it. I feel that at least one President's Page a year should be dedicated, by the doctors, to the Woman's Auxiliary. I am afraid that we, like the drowning man about the air, never actually appreciate what the Auxiliary means to us until we urgently need its help. To my knowledge it has never failed us and has actually gone far beyond the call of duty. This page therefore is written for it with all our love and appreciation.

The Woman's Auxiliary is an organization that works much more than the average doctor hears about. It is constantly busy and produces results whenever called upon. This is evidenced especially at the state medical meetings; however, there is much work done between meetings. I am sure none of us will ever forget the wonderful job the Auxiliary did at the last American Medical Association meeting in Miami. Those of us who were there were very proud of the tremendous job it did. I am sure it will never be surpassed.

President Martha Steward of the Florida Woman's Auxiliary has advised me that Princess Caradja of Romania will be the principal speaker at the Woman's Auxiliary luncheon at the Americana Hotel on May 11, 1962. All the doctors are invited to attend along with their wives. I am sure this will be a treat for you and I hope each one of you will avail yourself of this opportunity. President Martha has assured me that you will not be bored.

In my opinion 1962 is going down in the annals of history as one of the most crucial years in American medicine. If the King-Anderson bill is allowed to pass, socialized medicine is with us and out goes American medicine as it is today. Here again is where we come to the Auxiliary for help. The hard work which the Auxiliary did was a major factor in Senator Smathers' first campaign. I am sure the ladies who were active in that campaign have not forgotten any part of it, including making the potato salad.

Last month I tried to outline briefly AMPAC (American Medical Political Action Committee). The Auxiliary has recently been alerted to WHAM (Women Help American Medicine). All of the Auxiliary members have the kit outlining this program. See that you husbands look over this kit also.

With AMPAC and WHAM working together I feel that we can preserve American medicine as we know it now. The Auxiliary will do all within its power, but it will need plenty of help from the doctors, too. Give it this help even if it does take a little time away from your busy routine.





Editorials

Pulmonary Emphysema

The article on "Surgical Aspects of Pulmonary Emphysema" appearing elsewhere in this issue of The Journal is timely indeed since this is an extremely common disease and will, perhaps, be more prevalent in the future. The surgical relief of emphysema has its limitations, to be sure; however, there are definite indications for surgical resection as documented in the literature.[1-4] More commonly, surgical adjunctive measures are of great benefit to the pulmonary cripple with severe, diffuse pulmonary emphysema and superimposed acute tracheobronchitis.

We, in our group, recommend pulmonary resection for emphysema only in the following three manifestations:

1. Giant bullous or bleb formation with associated compression of relatively normal lungs thereby producing dyspnea;
2. Multiple ipsilateral spontaneous pneumothoraces or persistent bronchopleural fistula after spontaneous pneumothorax; and
3. Massive hemopneumothorax after spontaneous rupture of a bleb or bulla.

This latter indication has not previously appeared in the literature; however, we have personally treated three cases of massive hemothorax associated with rupture of bulla or bleb. Presumably this occurs secondary to tearing of a thin vascular visceroparietal pleural adhesion as the lung falls away from the chest wall because of the pneumothorax. The surgical procedure consists of thoracotomy and evacuation of hemothorax, coagulation or ligation of the bleeding points, and suturing the air leak on the emphysematous lung.

Resection in our 20 cases has included simple excision of bleb or bulla, segmental or subsegmental resection, and lobectomy. Five patients had bilateral resection, and two patients are at the interim between stages. There were no fatalities. We have been pleased with both subjective and objective improvement in the patients undergoing operation. Dyspnea, postoperatively, has been markedly reduced or absent, and pulmonary function studies revealed increased vital capacity and increased maximum breathing capacity. Several patients were occupationally disabled and were returned to productive employment following resection. Bullous emphysema is not limited to the elderly as exemplified by the age variations we encountered. Many were in the 30 to 40 year age group, and the extremes ranged from 22 to 70 years of age.

For the patients with severe diffuse pulmonary emphysema, supportive help is available in the form of bronchoscopy and tracheostomy during acute crises. These patients become critically ill when lower respiratory tract infections complicate their clinical course. Retained tenacious purulent secretions and associated bronchospasm decompensate the pulmonary cripple. Multiple bronchoscopies with aspiration or tracheostomy remove these secretions, open occluded bronchi, provide material for bacteriologic study and antimicrobial sensitivities, reduce the tidal air dead space, allow injection of intrabronchial antibiotics and antispasmodics, and may be used in conjunction with intermittent positive pressure units.

We have found diagnostic bronchography to be of distinct value in selecting patients for surgical therapy and in determining the extent of resection. Patients with relatively localized severe pulmonary emphysema can be dramatically improved by careful patient selection for pulmonary resection limited to the diseased area, and avoidance of postoperative complications. The surgical adjunct of tracheostomy or bronchoscopy combined with intensive medical therapy will also strikingly benefit the critically ill, elderly patient with severe diffuse pulmonary emphysema.

1. Warring, F. C., Jr., and Lindskog, G. E.: Surgical Management of Giant Air Cysts; Physiologic Improvement after Resection, Am. Rev. Tuberc. 63: 579-586 (May) 1951.
2. Dugan, D. J., and Samson, P. C.: Surgical Treatment of Giant Emphysematous Blebs and Pulmonary Tension Cysts, J. Thoracic Surg. 20: 729-748 (Nov.) 1950.
3. Allbritten, F. F., Jr., and Templeton, J. Y., III: Treatment of Giant Cysts of Lung, J. Thoracic Surg. 20: 749-760 (Nov.) 1950.
4. Feraru, F., and Morrow, C. S.: Surgery of Sub-pleural Blebs; Indications and Contraindications, Am. Rev. Tuberc. 79:577-590 (May) 1959.

FRANKLIN G. NORRIS, M.D.
ORLANDO

Of Him Who Has Much

American physicians, above all others of their colleagues in the world today, are most blessed with much—much knowledge, much freedom, much generosity and much ability to share of their plenty. For years American doctors have been answering the call of the needy sick in other nations who belong to the vast "fellowship of suffering and pain" by devoting their lives to overseas missions. Only a small percentage of American men of medicine have been able to give full time service in the mission fields, but among the majority who have remained behind to care for the needs of their fellow countrymen and women, many have sought ways to share their "much" with those who have so "little." In addition to supporting mission medical work by generous financial contributions, many doctors have evolved ways to give their services in needy areas for short periods of time, while still maintaining their practices at home. Several have utilized their vacation time year after year to lend a hand in some mission hospital or clinic. In recent years more and more physicians have become interested in "short term missionary" ventures and through the assistance of the Christian Medical Society or the Council for Overseas Christian Medical Work of the American Medical Association, they have found their way to areas where help is greatly needed.

This year at its annual meeting in June, the American Medical Association, recognizing both the great world health needs and the willingness of American doctors to help meet these needs, voted in the House of Delegates to publicize a program of recruitment of physicians volunteering for emergency service in the foreign mission field. Already this program is being speeded into action.

Five physicians from Tulsa, Oklahoma, members of the First Presbyterian Church of Tulsa, are giving up their practices for six week periods to serve voluntarily at the Miraj Medical Center in Miraj, India.

Dr. C. S. Lewis, one of these five Tulsa physicians, recently reported to the American Medical Association on the progress of the project labeled "Doctors in Asia." The first of the group of volunteer physicians flew to Miraj in mid-August. He returned at the end of September and the next doctor made the trip. In all, the five physicians will donate a total of 30 weeks to the program. The project is endorsed by the Tulsa County Medical Society. Funds for medical equipment, transportation and other expenses were raised through church and public contributions.

Other groups of American physicians are also becoming interested in the possibility of initiating a similar venture in their own communities. For example, several doctors met with Dr. Lewis during his visit to the American Medical Association to discuss the feasibility of adopting an overseas program which would provide medical care to another area of the world equally in need of such assistance.

Still another example of American physicians demonstrating their interest and willingness to serve in foreign mission fields on a temporary basis is shown by the large number of doctors who have written to the American Medical Association's Department of International Health in the last few months to inquire about such service. This new department administers a program approved last June by the House of Delegates whereby members of the American Medical Association may volunteer for service in the foreign mission fields on a temporary basis when emergencies arise. Cooperating in this program are missionary agencies representing every denomination sponsoring American medical missionaries.

Physicians interested in volunteering for such service are asked to write directly to the A.M.A. Department of International Health, 535 N. Dearborn Street, Chicago 10, Illinois, for a special application form.

Curtis D. Benton Jr., M.D.
Fort Lauderdale

A Place for a Scientist

Does a p.p.i. presentation have any significant advantage over the information obtained from an A-scope? Is the SGOT more helpful than an LAP when pancreatic disease is suspected? Will the pulse height analyzer make your medical acumen less important, or more? What is an m.e.v.? What is noise interference? What is up, or down, in the practice of medicine?

Medical jargon has become confusing to those physicians who have been away from their formal training for more than a few years. Some terms which have been borrowed from the language of the engineer, the physicist, the chemist and the mathematician may cause the older physicians to

pause in their thinking, being unable at times to follow the significance of such expressions as "the complexities of extracorporeal circulation with its bubble oxygenators and heat exchangers." They shrink from solemn discourses delivered by visiting professors from the universities on the merits of the Van de Graaff linear accelerator.

Medicine has been an art; it always will be, and the heart of the physician must be greater than his mind. Nevertheless, the scientist, whether geneticist, physicist, chemist or engineer, has been telling the physician much of what he knows. When the scientist speaks, the physician must fully comprehend not only his vocabulary and formulae but the significance and application of his message. How is the physician, swamped by a thousand demands and obligations, to get the scientist's message promptly and accurately?

The professors in the universities with vast preclinical resources, research programs and extensive paramedical departments may obtain answers first hand to their questions. Working daily with learned men, they can and do adapt and adopt, strive and contrive, to bring to their clinical departments those things which belong there. To the physician in private practice, these relationships are not possible.

There are medical journals, meetings, house calls and telephone calls, and little time for exploring the world of the scientists; therefore, the physicians in private practice need a scientist of their own who will serve as personal interpreter and guide. Through him the smaller hospitals could provide technical information—theoretical and practical, current and ever changing. This scholar, known by the title of scientist, may work in the x-ray department, in the laboratory or as director of medical education. He should be able to bend an ear or to bend a glass, equally capable of explaining the necessity of using milliequivalents or the place of isotopes, their handling and disposal. His ideas should be sound and meaningful, and his background in mathematics, physics and chemistry will have provided practical experience to accompany his knowledge.

The person with these qualifications may be found by the hospital with 200 or more beds in the university which created him, and he can be coaxed to leave by suitable inducements. The hospital can afford a dietitian, an assistant administrator, an orderly, and brains are as essential as brawn. The scientist will pay his way by bringing vital and challenging knowledge to the hospital and its staff; his presence will stimulate the acquisition of new and better tests and regimens in all departments.

The physicians in private practice are entitled to assistance from the world of science and technology. They should not depend solely on "refresher courses," the drug salesmen, and the almost incomprehensible advertisements in medical journals. They need a partner to work daily with them; it is not too late to catch up. Soon it will be.

Courtlandt D. Berry, M.D.
Orlando

The Doctor's Dilemma

The practitioner attending a child with a febrile respiratory infection is often not certain of the appropriateness of the therapy he employs. He is aware that the majority of respiratory infections in children are of viral origin; however, he knows that secondary bacterial invasion, particularly of the middle ear, occurs frequently. Often he cannot be certain on clinical grounds whether the infection he sees is of viral or bacterial etiology. In the case of exudative pharyngitis, for example, unless he obtains cultures, he will not be certain that the infecting agent is group A beta hemolytic streptococcus. Viral agents may be responsible for an identical clinical picture. Proper therapy in this situation must depend on bacteriological study of the pharyngeal flora. Although certain clinical entities, such as herpetic stomatitis and herpangina, are easily recognizable, they comprise a small percentage of the respiratory infections he sees.

The case most commonly encountered is that of the infant or child with fever, coryza, cough and perhaps hyperemia of the tympanic membrane. In the young infant, the presence of bronchial rales or wheezing is a common accompaniment of this condition and may be present with little or no fever. In this type of situation, throat cultures usually yield a variety of organisms, most of them normal inhabitants of the pharynx. It seems very likely that in the majority of these cases viral

agents are etiologic factors, and the course of the illness is usually self-limited. The value of antimicrobial drugs in this type of situation is open to question.

Studies which have as their purpose the testing of the efficacy of a particular drug in respiratory infections should include control cases. The value of such a study is further enhanced if, during the test period, the investigator is unaware of which patients are receiving the drug. The study also should include some statement as to the presence or absence of serous otitis media at the end of the treatment period as this has become one of the most troublesome complications of respiratory infections in children. Although the limitations of the usefulness of cultures have been referred to, such cultures should be included in the type of study under discussion. They will in particular instances clarify the etiology of the infection.

Unless the requirements to which reference has been made are satisfied, studies of the efficacy of drugs will do little to resolve the physicians' dilemma.

J. K. DAVID JR., M.D.
JACKSONVILLE



Clinical Comment

Midwinter Meeting
Florida Obstetric and Gynecologic Society

The Midwinter Meeting of the Florida Obstetric and Gynecologic Society was held at the Galt Ocean Mile Hotel in Fort Lauderdale, December 1-3, 1961. Guest speakers were Dr. Robert N. Creadick, Associate Professor, Department of Obstetrics and Gynecology, Duke University Medical Center, Durham, N. C., and Dr. Robert E. L. Nesbitt Jr., Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York Upstate Medical Center, Syracuse, N. Y.

The first scientific session was called to order by the President, Dr. James R. Sory of West Palm Beach, on Saturday morning. Four case reports were presented: "Unexplained Vaginal Bleeding in the First Trimester of Pregnancy" by Dr. Raymond P. Nolan of Hollywood; "Intra-Epithelia Carcinoma of the Vagina" by Dr. Thomas A. Rodenberg of Hollywood; "Carcinoma of the Cervix Complicating Pregnancy" by Dr. William D. Wallace Jr. of Fort Lauderdale; and "Pathological Examination of a Post-Partum Uterus Containing Dacron" by Dr. William H. Kirkley of Fort Lauderdale. An interesting and instructive panel discussion was then presented by Dr. Nesbitt, Creadick, James H. Ferguson of Miami and James M. Ingram of Tampa with Dr. E. Frank McCall of Jacksonville serving as moderator.

The second scientific session was opened December 3 by Dr. Creadick, who gave a most interesting presentation on "Psychosomatic Factors in Obstetrics and Gynecology." Dr. Creadick's frank and forceful presentation of the environmental factors associated with the etiology in the formation of latent psychosomatic trauma covered a panoramic review from puberty to the postmenopausal and senile state. His observation was that the menopause frequently reflects the stages of puberty insofar as their psychosomatic adjustment is concerned. Thus a well tempered and emotionally integrated girl, at the time of menarche, would most likely experience a tranquil and even transition from the childbearing phase of her life into that of the postmenopausal period. Many of the harassing problems attendant upon the treatment of a frigid female were presented and some suggestions of an unencumbered approach to the fulfillment of coitus were explained. A so-called "somatic postural inversion" may eliminate a deep-rooted subconscious frustration. It may, on the other hand, give a masochistic expression of fulfillment.

The concept of the pre-senile female, as an active member of the sexual community, no longer remains an enigma. The need for counsel in this region may also require an awareness of some of the anatomical and physiologic deterioration which may be improved by simple surgery, lubricants and hormone creams, to develop a more luxuriant vaginal epidermis.

Although there was little discussion of Dr. Creadick's presentation, there was a general feeling that his forthright expression reflected the agreement of the majority of the experienced physicians present.

Dr. Nesbitt spoke on "Clinical Evaluation and Management of Patients Who Are Likely to Abort." He stated that it was found, after a careful study of histories of several thousand pregnant women, that at least 20 per cent had some bleeding during their pregnancy. He thought glandular problems should be corrected if definitely found to be present; otherwise, conservative treatment. He stated that if they reach the cramping stage with bleeding, two thirds will abort regardless of what therapy is used. In a series of cases in which cytologic study was made at weekly intervals, it was concluded that the outcome could be predicted with some accuracy by the type of smears as high cornification and karyopyknotic index changes take place. Several of the prognostic factors in abortion are: age, social status, health, previous reproductive loss, endocrine imbalance, pelvic conditions and preconception therapy.

Dr. Nesbitt closed with the remark that probably, in the near future, we will have a glandular product that will be able to produce ovulation.

Curtis H. Sory, M.D.
FORT LAUDERDALE

Aids to Practice



Question: Has a standard insurance reporting form been developed and made available to make it easier to file claims for patients who have commercial health insurance?

Answer: Yes, a standard "Attending Physician's Statement" has been developed in cooperation with the Health Insurance Council, and approved by the Council on Medical Services of the American Medical Association and by the Florida Medical Association. It may be identified by the "HIC" circular emblem printed on the form. A supply of the standard form, COMB-1, may be made up by your printer or ordered from Ambrose, The Printer, P.O. Box 5536, Jacksonville 7, Fla. (300 sheets, in three pads, costs $5.67).

Question: What should I do if an insurance company submits a long, involved claim form that is not a standard HIC approved claim form?

Answer: Provide yourself with a supply of the HIC "Attending Physician's Statement" and complete your report on this simplified form. Attach the HIC form to that sent to you by the insurance company, and send both to the insurance company. The Health Insurance Council represents over 700 insurance companies writing over 90 per cent of the health insurance policies in the United States. If you send in the HIC standard form, few companies will reject it.

Question: Recently a patient attempted to reach me in an emergency from an unlisted residence telephone. The number I was given to call back was incorrect, and the telephone company would not give me the unlisted number. How can I reach a patient under these circumstances?

Answer: Try dialing "113" and asking for the supervisor. Tell her your problem. Although she cannot give you the unlisted telephone number, she can telephone your patient herself and ask the patient to call you again.

Question: Is there anything I can do when it appears an insurance company is not being reasonable in its dealings with me regarding a claim?

Answer: The Florida Medical Association has urged all county societies in Florida to formulate and utilize insurance review committees. Their

function is to study such problems in the relationship between the health insurance industry and the medical profession, not in the sense of a grievance committee, but to determine and help bring about what is reasonable in such instances. The Health Insurance Council and the Florida Medical Association are achieving excellent rapport through the Association's Committee on Commercial Health Insurance headed by Dr. Duncan T. McEwan of Orlando.

Question: May I "borrow from Uncle" if I do not have enough cash to pay up my 1961 income tax?

Answer: Yes, submit your proposal of payment (if not in full with your return) with completed form 1040 no later than April 16, 1962. But better, borrow from your regular banker, and do not create a special status for yourself with Internal Revenue Service.

Association News

County Medical Society Presidents and Secretaries Fourth Annual Conference

Newly elected presidents and secretaries of the component county medical societies of the Florida Medical Association gathered on January 13 and 14, 1962, at the Hotel Robert Meyer in Jacksonville for the fourth annual conference the Association has sponsored to orient the incoming officers. The registration reached 107, and officers from 24 out of 40 county societies represented 93 per cent of the membership.

President S. Carnes Harvard of Brooksville presided at the session on Saturday afternoon. In his opening remarks he explained the Association's purpose in fostering the conference annually and expressed the gratification of the Board of Governors over the increasing attendance and participation in the meeting each year. This approach to closer liaison between the Association and its component county societies is proving a fruitful means of advancing the program of medicine from the vantage point of the state level and providing a channel for expression of the views, problems and desires of the membership of the constituent societies.

Speaking on "American Medical Association's Programs," C. Joseph Stetler, LL.B., Director of the Legal and Socio-Economic Division of the American Medical Association, surveyed the broad scope of the national organization's activities, emphasizing some of the projects about which many doctors seem not to be too well informed. The new drug program now being inaugurated will interest all physicians. To cope with the nation's paramount health problem, medicine's parent body is sponsoring the first national Conference on Mental Health. Under the direction of an able committee it is preparing a guide to medical rating of permanent physical disability. It is seeking a larger place for the subject of food and nutrition in the medical school curriculum and in the care of the aged. Its Congress on Quackery held last year proved a highly successful step in effecting cooperation between government and private agencies in this fertile field. With the merger of two former foundations into the American Medical Education and Research Foundation, a new student loan program is under way; studies are being expanded in maternity and newborn care, an area in which Florida's chief delegate to the House of Delegates, Dr. Reuben B. Chrisman Jr., of Miami, has a vital role; inquiry into sports injuries tends to place responsibility on faulty or inadequate equipment; and the medical aspects of disaster care are receiving major attention. Also, inquiry continues into the cost of health care, a project pioneered by the late Dr. Louis M. Orr of Orlando.

In addition, the medical discipline committee is diligent in its duties, and there are many ramifications to the activities of the legal staff. Regional conferences have proved a successful recent innovation. A new Department of International

Health has been established, which cooperates with medical missionaries around the world and promises to be an important factor in global health. In concluding his enlightening portrayal of a few of the manifold activities of the American Medical Association, Mr. Stetler observed that 600 of the 1,400 bills presented to the 1961 session of the Eighty-Seventh Congress affected medicine. He reminded the doctors that they, not the headquarters staff, are the American Medical Association and on whether they at the individual and county level choose to be observers or participants depends in large measure the outcome of the legislative battles that lie ahead during the current session of the Congress and beyond.

Dr. Edward R. Annis of Miami, Chairman of the Committee on State Legislation, spoke on "Medical Legislation—National and State," emphasizing at the outset that effective scientific medicine must be free medicine and that doctors have to be right in the cause they espouse and must know the issues. He reviewed the state program, pointing out that Florida is one of 38 states in which the Kerr-Mills bill has now been implemented in whole or in part and that all eight of Florida's representatives are committed against the King-Anderson bill. In reviewing national medical legislation, he skillfully analyzed the medical aspects of President Kennedy's State of the Union message to the Congress, exposed the fallacies and pitfalls inherent in the program proposed and explained the forces promoting it.

The subject presented by Dr. Henry J. Babers Jr. of Gainesville, Chairman of the Committee on Fee Schedules, was "Medical Economics." His four point comprehensive approach covered relative values, the Florida Workmen's Compensation Fee Schedule, Blue Shield and commercial health insurance. His appeal to all physicians was that they give a tithe of their time and thought to organized medicine.

The many facets of the subject of "Medical Services" were presented graphically by Dr. Samuel M. Day of Jacksonville, the Association's Secretary-Treasurer. Among them were the Florida Medical Investment Trust and the various Association insurance plans. He urged that the county medical society officers familiarize themselves and their membership with these plans so that they may take full advantage of them. After reviewing the various state programs for the indigent and disabled, he said that Florida doctors gave in free care last year more than twice as much as the entire reported community chest funds of the state. His concluding plea was to be informed and let the people know so that they will choose the right way, not the left way.

At the session on Sunday morning, January 14, presided over by Dr. Robert E. Zellner of Orlando, President-Elect of the Association, a three hour period was devoted to the county medical society officers for consideration of their programs and problems. Discussion ranged from emergency calls, staffing of hospital emergency rooms, hospital staff attendance and admission of osteopaths to hospitals to press relations and the listing of specialties in the telephone directory. It was reported that the Dade County Medical Association has a committee on multiple medical meetings which has won the cooperation of that society and 11 local hospitals in designating one night a month for all meetings, beginning at 4:30 p.m. and allowing 45 minutes for each staff meeting. The plan features a social hour and dinner and medical motion pictures to cover the lapses in time between meetings for the individual doctors, with the association's meeting concluding the series of meetings.

Much of the morning's discussion centered around commercial health insurance. Dr. Duncan T. McEwan of Orlando, Chairman of the Committee on Commercial Health Insurance, reviewed the relationship of the Health Insurance Council with organized medicine, the simplifying of forms and the function and organization of review committees in the county medical societies. He was followed by Mr. Victor Hruska of Jacksonville, Assistant General Manager of the South Central Home Office of the Prudential Insurance Company Of America and Chairman of the Medical Relations Committee of the Florida Health Insurance Council. This council was established by the insurance industry to promote liaison with the medical profession and has a membership of 95 per cent of the companies writing health insurance. The speaker stressed cooperation of county medical society review committees and discussed misrepresentation in selling coverage, provision for outpatient diagnostic work-ups, excessive fees when policies are carried with more than one insurance firm, professional liability insurance with coverage for members of grievance committees, and availability of a model county medical society charter. In conclusion, Dr. McEwan urged the county medical society officers to make use of the speakers' bureau.

News

Drs. John W. Snyder and Walter W. Sackett Jr. of Miami and Dr. Warren W. Quillian of Coral Gables have been re-elected to the Board of Trustees of the University of Miami.

A Symposium on Clinical Allergy, the first in a series of postgraduate courses to be presented by the Mound Park Hospital Foundation in cooperation with the Department of Medical Education of Mound Park Hospital, the Bay Pines Veterans Administration Center and with joint sponsorship of the American Academy of General Practice, has been scheduled for April 19-21 in the auditorium of Mound Park Hospital at St. Petersburg. Florida physicians on the faculty include Drs. G. Frederick Hieber, James W. Allee and Walter L. Schafer of St. Petersburg and Dr. Morris Waisman of Miami.

The 57th annual meeting of the American Thoracic Society will be held May 21-23 at Miami Beach with headquarters in the Deauville and Carillon hotels. Dr. Asher Marks of Miami is chairman of the medical sessions committee and Dr. Charles F. Tate Jr. of Miami is chairman of the exhibits committee.

The Augusta Postgraduate Medical Assembly sponsored by the Richmond County Medical Society of Augusta, Ga., has been scheduled for April 2-4. Dr. Max Michael Jr. of Jacksonville will present a paper entitled "Some Observations on Bacteremia" and participate in a panel discussion as a part of the program for the Internal Medicine Section.

The Hillsborough County Medical Society and the Hillsborough County Health Department with active participation of the Florida State Board of Health will continue the community oral polio vaccination program during April in Hillsborough County using trivalent oral vaccine prepared from Sabin strains of attenuated polio viruses produced and donated by Lederle Laboratories.

Dr. M. Eugene Flipse of Miami is chairman of the Department of Preventive Medicine and Public Health of the University of Miami School of Medicine. The Department was a section in the Department of Medicine. It was granted independent status to become effective February 1.

The publication entitled "Current Literature on Venereal Disease," which contains abstracts of articles from almost 1,000 domestic and foreign journals, is distributed regularly without charge to physicians upon request to Communicable Disease Center, Atlanta 22, Ga., Attention: William J. Brown, M.D., Chief, Venereal Disease Branch.

Dr. Edward L. Cole Jr. of St. Petersburg has been selected that city's outstanding citizen by the St. Petersburg Junior Chamber of Commerce. Dr. Cole was cited for "his recognition of the medical profession's responsibility to the community and participation in civic matters pertaining primarily to his professional field of medicine." He is president of the Pinellas County Medical Society.

The Monroe County Medical Society and the medical staff of the U. S. Naval Hospital at Key West met jointly the last of January for a program on the subject "Diagnosis and Treatment of Mammary Cancer." Speakers were Dr. Charles J. McPeak, attending surgeon of the Memorial Hospital and Sloan Kettering Institute, and Dr. Ralph Herz Jr., director of the Endocrine Clinic of The French Hospital, New York.

Meetings

March

Annual Seminar, Watson Clinic, March 3, Lakeland.

Post Graduate Cardiac Surgical Colloquia, March 10 and March 24, Pathology Conference Room, Jackson Memorial Hospital, Miami

6th Annual Professor Pro Tempore Program in Surgery, March 19-24, Mount Sinai Hospital, Miami Beach

Seminar on the Application of Basic Sciences to Clinical Practice, March 29-30, College of Medicine, University of Florida, Gainesville

April

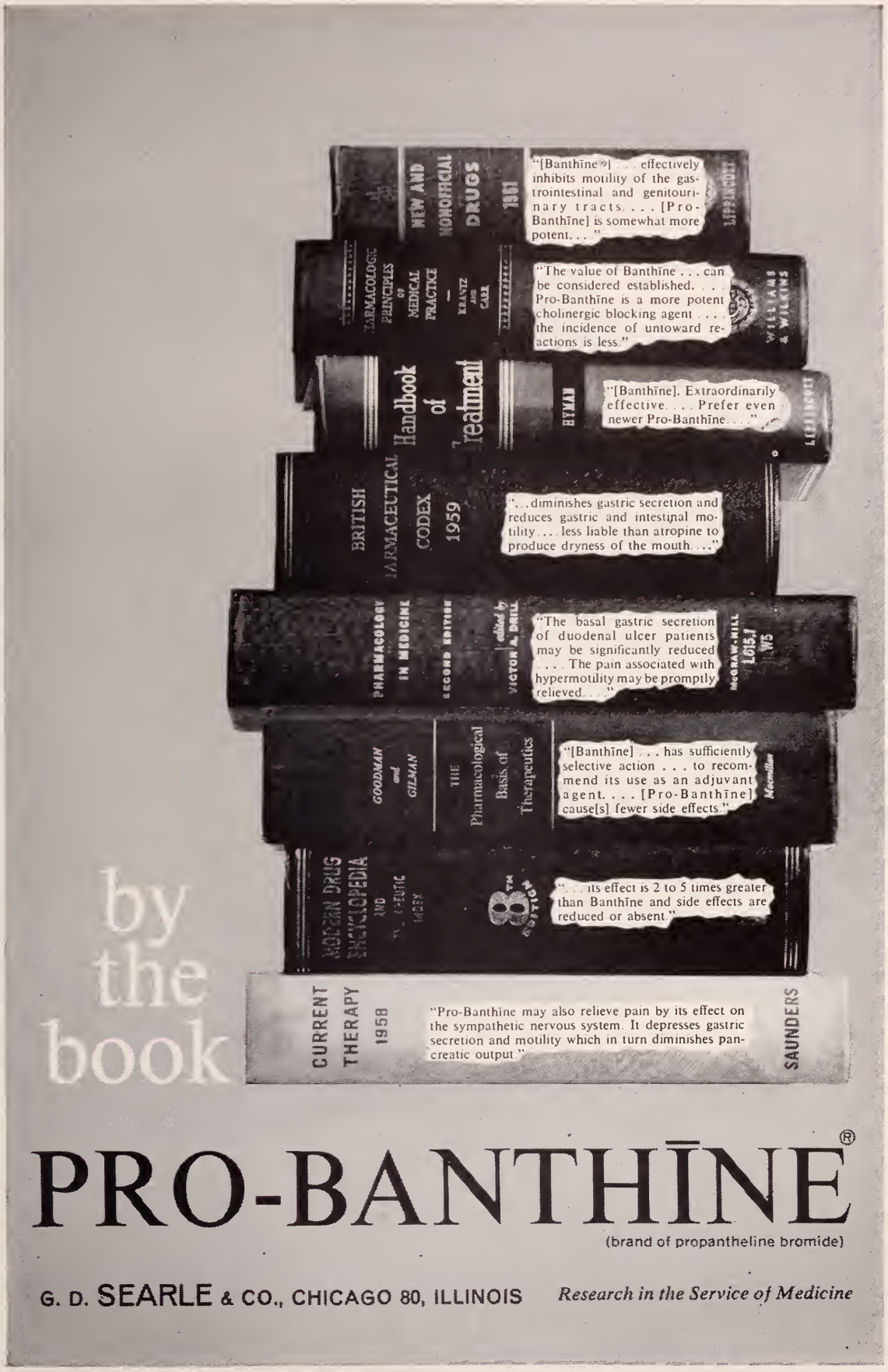
Post Graduate Cardiac Surgical Colloquia, April 14 and April 28, Pathology Conference Room, Jackson Memorial Hospital, Miami

Symposium on Clinical Allergy, April 19-21, Mound Park Hospital, St. Petersburg

May

Florida Medical Association, 88th Annual Meeting, May 10-13, Hotel Americana, Miami Beach

Florida Thoracic Society, May 21, Deauville Hotel, Miami Beach



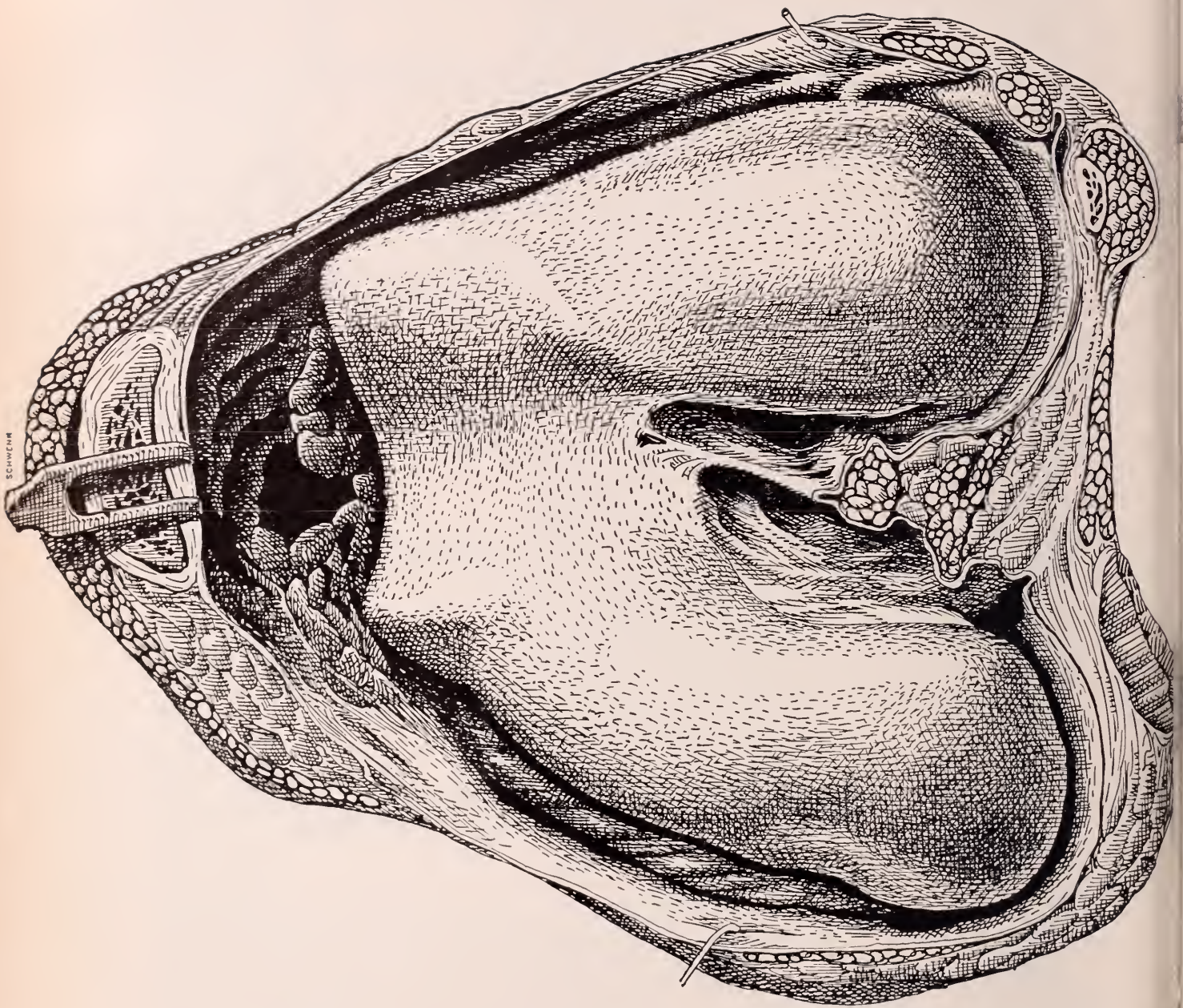
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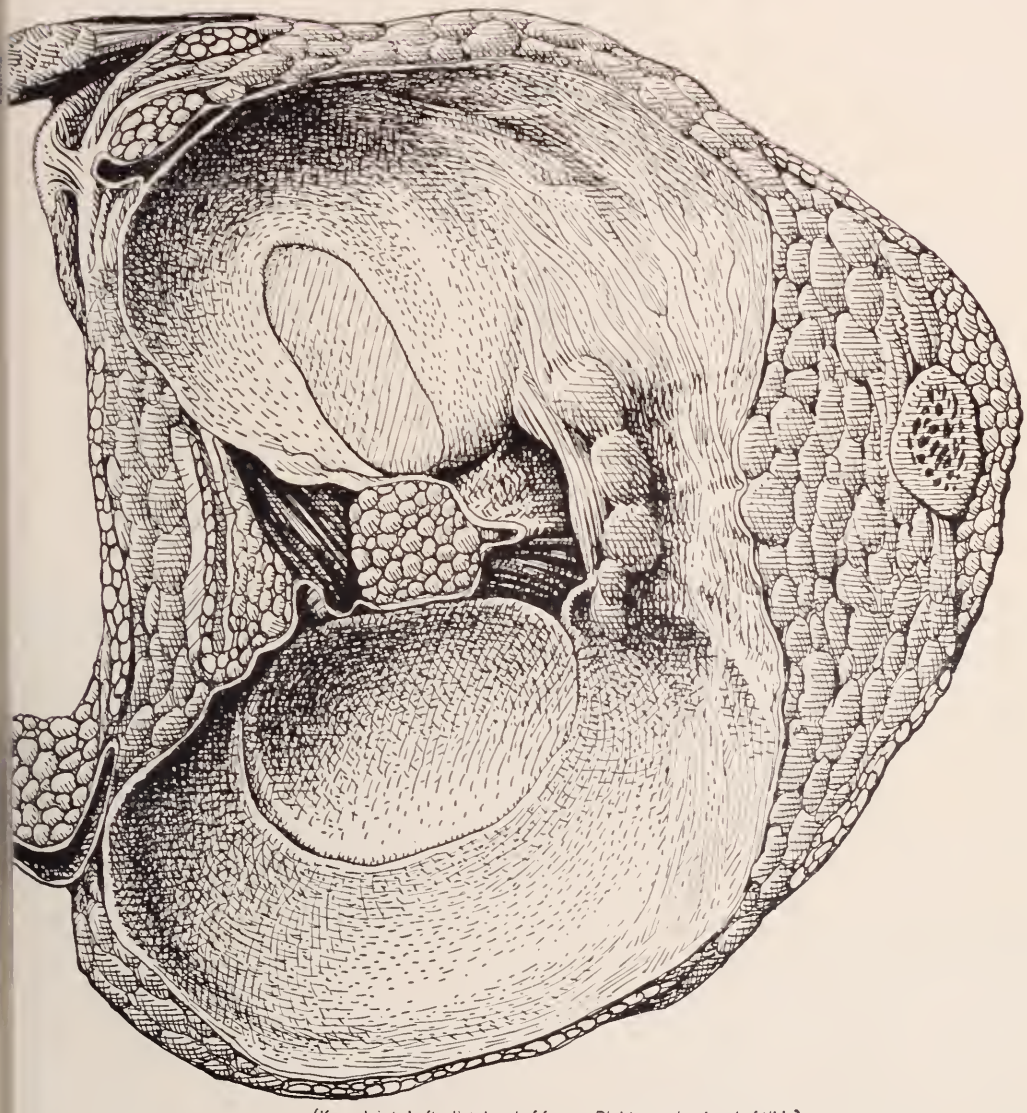
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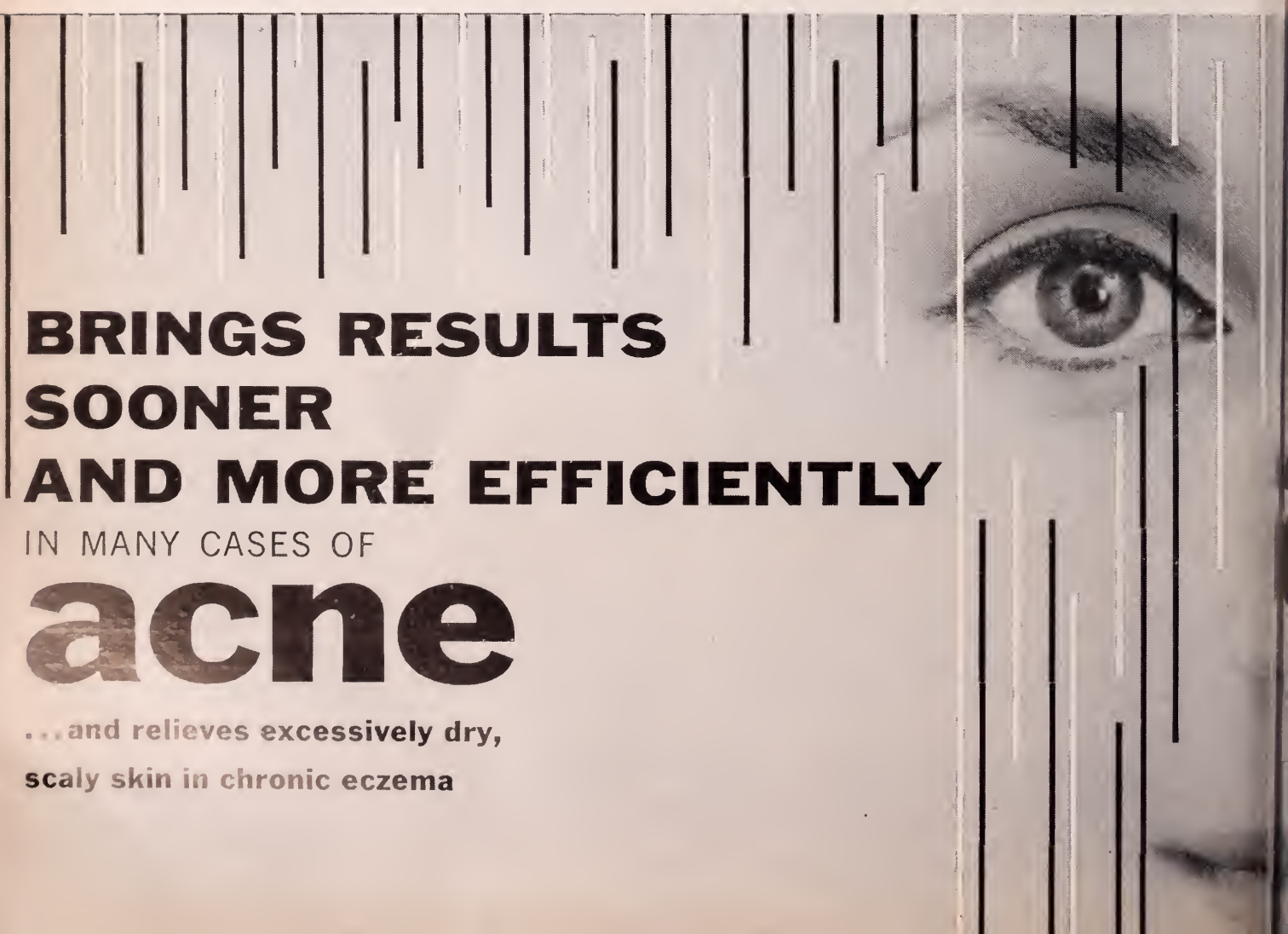
Deaths

Baker, Juel M., Miami; born in Richland, Ind., in 1899; University of Louisville School of Medicine, Louisville, Ky., 1923; veteran of World War II; had engaged in private practice in Miami for 36 years; was a charter member of the Dade County Medical Association and also held membership in the American Medical Association; died Nov. 7, 1961, aged 61.

Hopkins, George Dearborn II, Fort Myers; born in 1923; State University of New York Downstate Medical Center, New York; interned at the Medical College of Virginia, Hospital Division, Richmond, Va.; served in the Army Medical Corps in Korea; entered the practice of internal medicine in Fort Myers in 1953; was a member of the American Medical Association, American Heart Association and Florida Trudeau Society, and was a past president of the Lee-Hendry County Medical Society, the local medical society, and the Lee County Tuberculosis and Health Association; was chairman of the Lee County Welfare Board and of the 200 Club, of which he was a founder; was active in promoting the local Layman's Medical Forum; died Sept. 17, 1961, aged 38, in the crash of an airliner in Chicago.

Lassiter, Wilburn, Gainesville; born in Gainesville, Dec. 4, 1879; Tulane University School of Medicine, 1903; was in charge of the City Health Department from 1917 until it was combined with the Alachua County Health Department in 1948, and from 1948 to 1956, when he retired, served the county health unit as assistant health officer; was examining physician for the Selective Service Board from 1942 to 1947; was a past president of the Alachua County Medical Society and held membership in the American Medical Association; died Oct. 5, 1961, aged 81, after an extended illness.

Wade, Hugh Wesley, St. Petersburg; born in Quitman, Ga., in 1889; Atlanta College of Physicians and Surgeons, 1912; practiced medicine in Florida for half a century, coming from Dade City to St. Petersburg to engage in the practice of internal medicine there for 42 years; served in the Army Medical Corps during World War I as a captain in the 80th Division; was a past presi-



dent of the Pinellas County Medical Society and a member of the American Medical Association; died January 11, aged 72.

Williams, Norman E., Daytona Beach; born in Micanopy in 1907; Tulane University School of Medicine, New Orleans, 1935; served an internship at Tennessee Coal and Iron Hospital in Birmingham, Ala., and a residency at Cleveland Clinic Hospital in Cleveland, Ohio; had a one year fellowship at Imogene Bassett Hospital, Cooperstown, N. Y., and a two year fellowship at Columbia-Presbyterian Medical Center, New York City; served five years as a commander in aviation medicine in the United States Navy; located in Daytona Beach in 1946; was a diplomate of the American Board of Internal Medicine, a fellow of the American College of Cardiology, a member of the American Medical Association and the Volusia County Medical Society, a past president of the Halifax Hospital medical staff; founder of the Heart Association of Volusia County; member of the board of the Florida Heart Association; died Dec. 10, 1961, aged 53, as the result of an automobile accident in New Smyrna Beach.

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"Nutritional Problems and Operability in the Aged"
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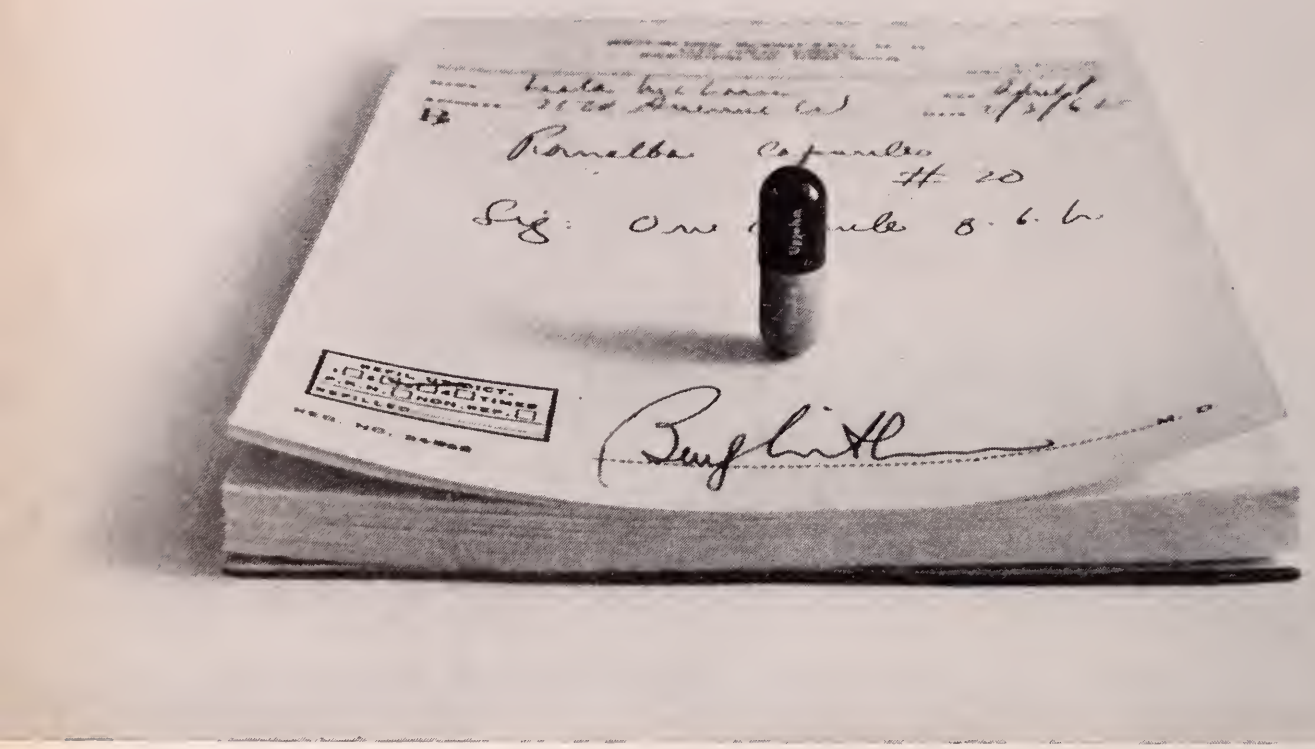
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Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

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Woman's Auxiliary

Doctors' Day — 1962

Americans are a people who take great delight in setting aside "days" for special attention. Some of these are worthwhile, some are foolish, and some are utterly ridiculous, but one "day" is a very special one to doctors' wives — this is Doctors' Day, March 30.

The beginning of Doctors' Day goes back to 1933, when the suggestion was made by a physician's wife in Georgia that a day be observed annually on which to honor members of the medical profession, both living and dead, with some act of kindness, gift or tribute. She presented to her local auxiliary the idea of having a day on which to honor the practitioners of the Medical Arts. The suggestion met with immediate approval, and later was adopted by the Georgia State Medical Auxiliary, and after being introduced to the Woman's Auxiliary to the Southern Medical Association at the 1935 St. Louis, Mo. Annual Meeting, it has become an integral part of the program of this auxiliary. The Woman's Auxiliary to the American Medical Association adopted a resolution recommending that each state select a day which would celebrate an outstanding medical achievement in their own state, and several chose Doctors' Day, March 30 in honor of Georgia.

March 30 was not chosen at random but to commemorate one of the greatest discoveries in medical history. It was on that date in 1842 that Dr. Crawford W. Long, the famous Georgia physician, first used ether as an anesthetic agent in a surgical operation.

The red carnation is a symbol of Doctors' Day and was adopted by the auxiliary in 1949. It is used wherever plans call for flowers in paying tribute to the medical profession on the day which is celebrated in their honor.

Florida for several years has had 100 per cent observance of Doctors' Day throughout the counties. Every organized auxiliary plans some type of celebration to honor her physicians.

At the beginning of this auxiliary year, it was suggested that Doctors' Day could take on additional meaning if each physician would celebrate the day by having a physical check-up. Not too long ago I heard a lawyer say that he was

ashamed to admit that only about 30 per cent of lawyers had wills. What per cent of our physicians have had the "yearly check-up" they advocate for their patients? Let's make March "annual check-up" month! Your F.M.A. President, and the husband of the auxiliary president have agreed to be "good examples."

Doctors' Day is set aside to pay tribute to those who are unselfishly dedicated to the health and welfare of the public, but we admit to being *selfishly* dedicated to *your* health and welfare. Please keep this in mind, won't you?

Mrs. Robert F. Dickey
Doctors' Day Chairman

New Members

The following doctors have joined the State Association through their respective county medical Societies.

Active

Anderson, Wilbert R., St. Petersburg
Armstrong, Louis F., St. Petersburg
Benefield, Joseph I., Lake City
Burke, Herbert A. Jr., Jacksonville
Burns, Emil E., St. Petersburg
Byrnes, Victor A., St. Petersburg
Crist, Charles J., St. Petersburg
Diamandis, Themistocles J., Tarpon Springs
Downing, John D. Jr., Largo
Duncan, Thomas A., St. Petersburg
Gillespy, Thurman Jr., Daytona Beach
Gorman, Jerome D., Dade City
Grossnickle, James W., Stuart
Mela, Henry Jr., St. Petersburg
Neller, Roth D., Clearwater Beach
Parrish, Bruce E., Gulfport
Pryor, Howard I, St. Petersburg
Purvis, William E. III, Dunedin
Shedden, William M., Ormond Beach
Shuttleworth, John E. S., Clearwater
Stephens, Hinson L., Orange Park
Vizzi, Ferdinando F., Tampa
Welch, George H. Jr., St. Petersburg
Wilson, John T., Lake City
Wunderlich, Ray C. Jr., St. Petersburg

Associate

Bailey, S. Joseph, Jacksonville
Baumgarten, Harold, Jacksonville
Bowers, John A., Jacksonville Beach
Brown, Carleton J., Jacksonville
Cox, Don R., Miami
Crane, Edwin D. III, Tallahassee
Day, James F., Jacksonville
Donelan, G. Lynn, Coral Gables
Draper, Arthur D. Jr., Jacksonville
Ebbinghouse, Joseph C., Jacksonville
Epstein, Lester, North Miami
Evans, John T. Jr., Jacksonville
Fox, Channing H., Fort Lauderdale
Lehr, David E., Miami Beach
McCormick, John T., Jacksonville
McKay, Ernest G., Jacksonville Beach
Pollock, James H., Boynton Beach
Potts, William L., Hollywood Beach
Risi, George F., Jacksonville
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Zubero, Jose L., Jacksonville

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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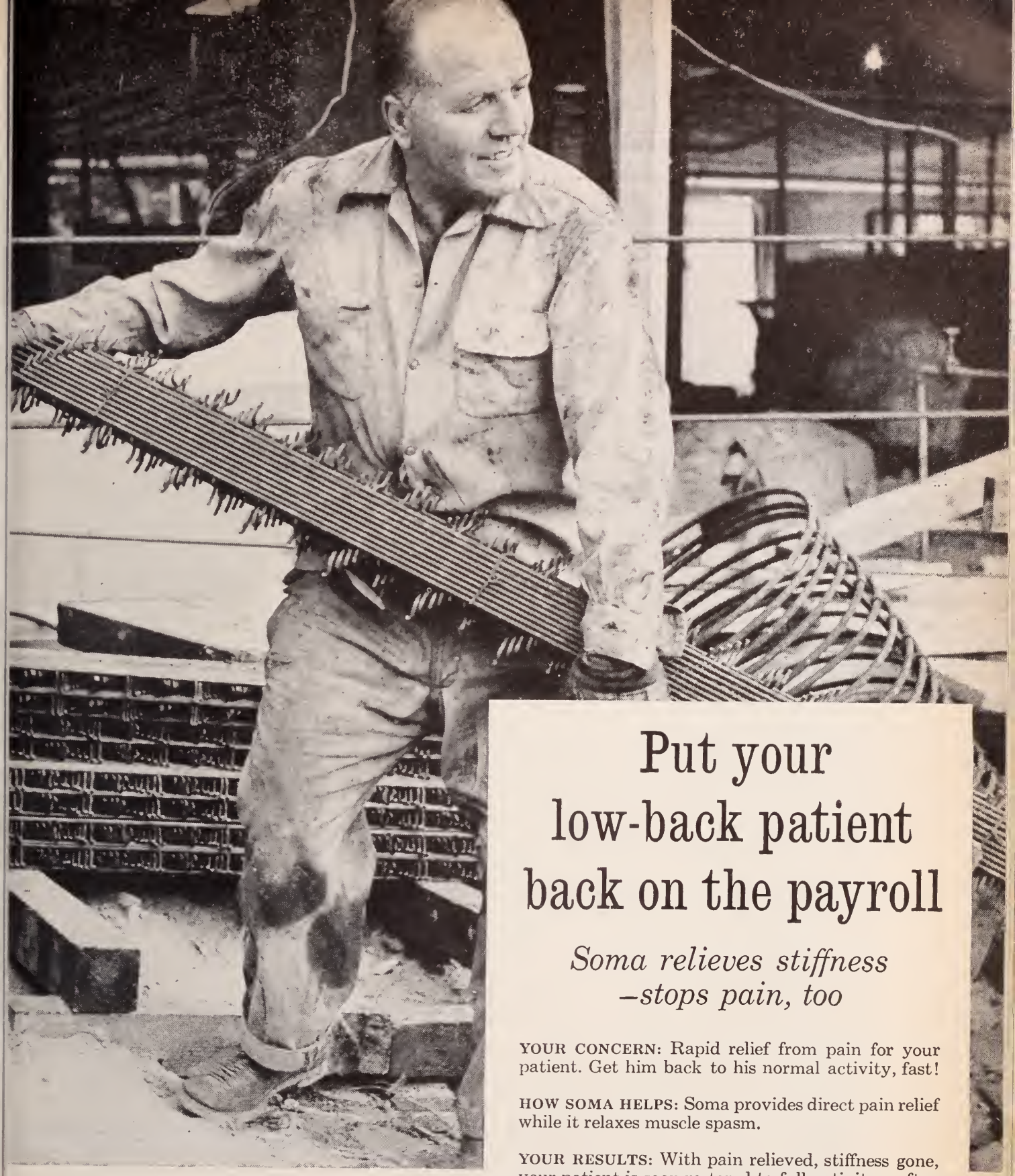
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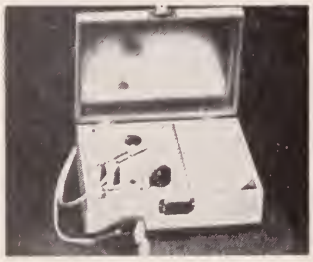


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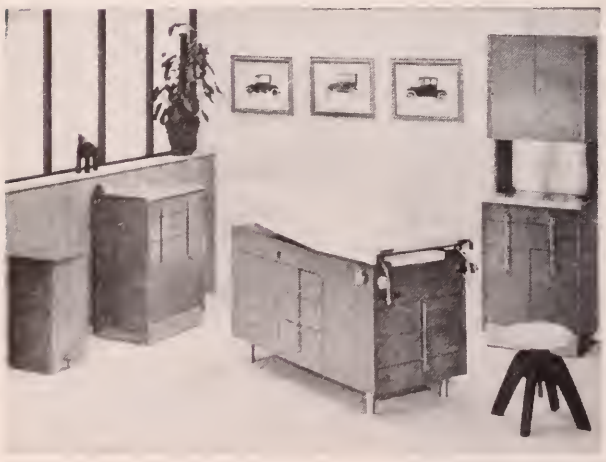
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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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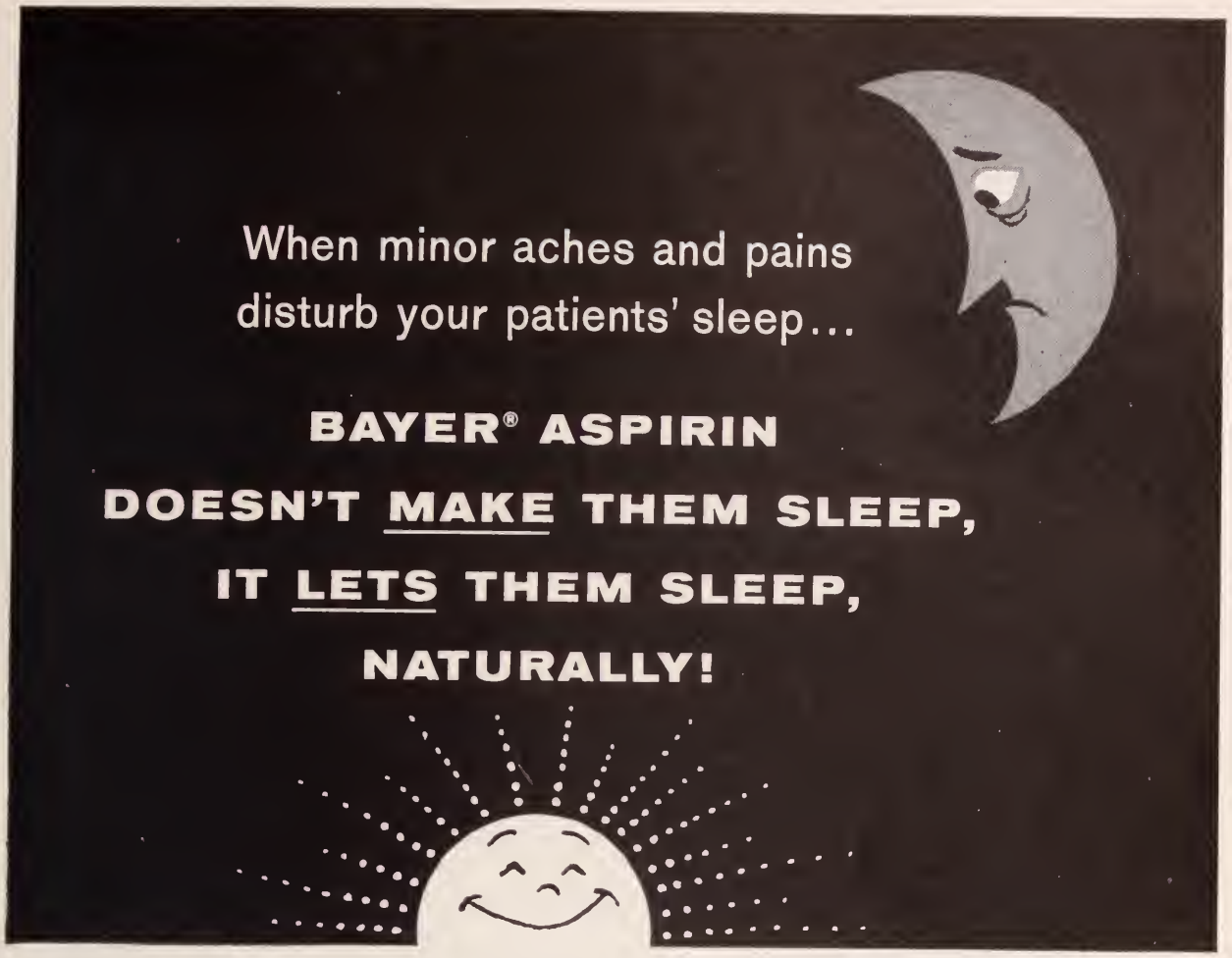
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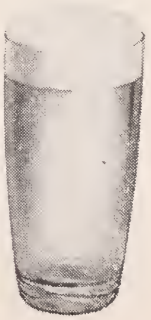
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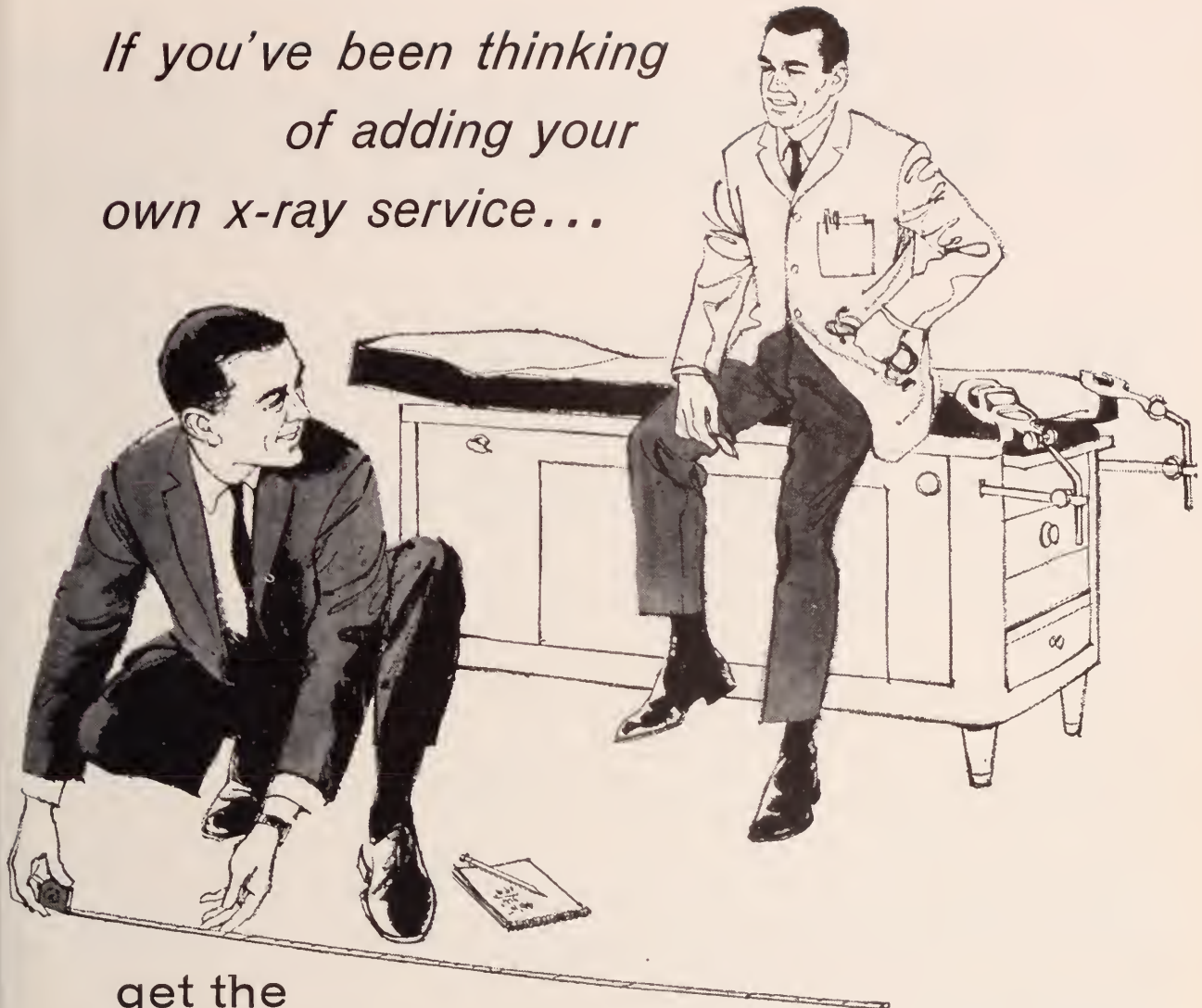
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W. and Fong, T. C. C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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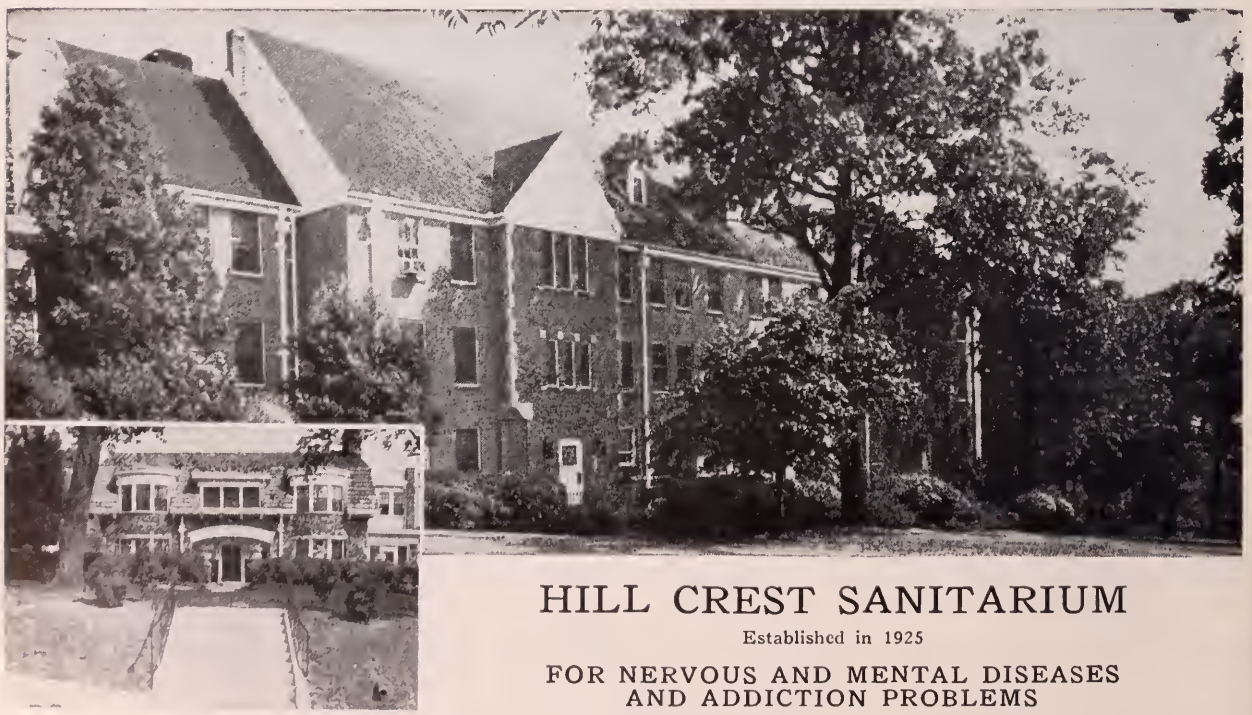
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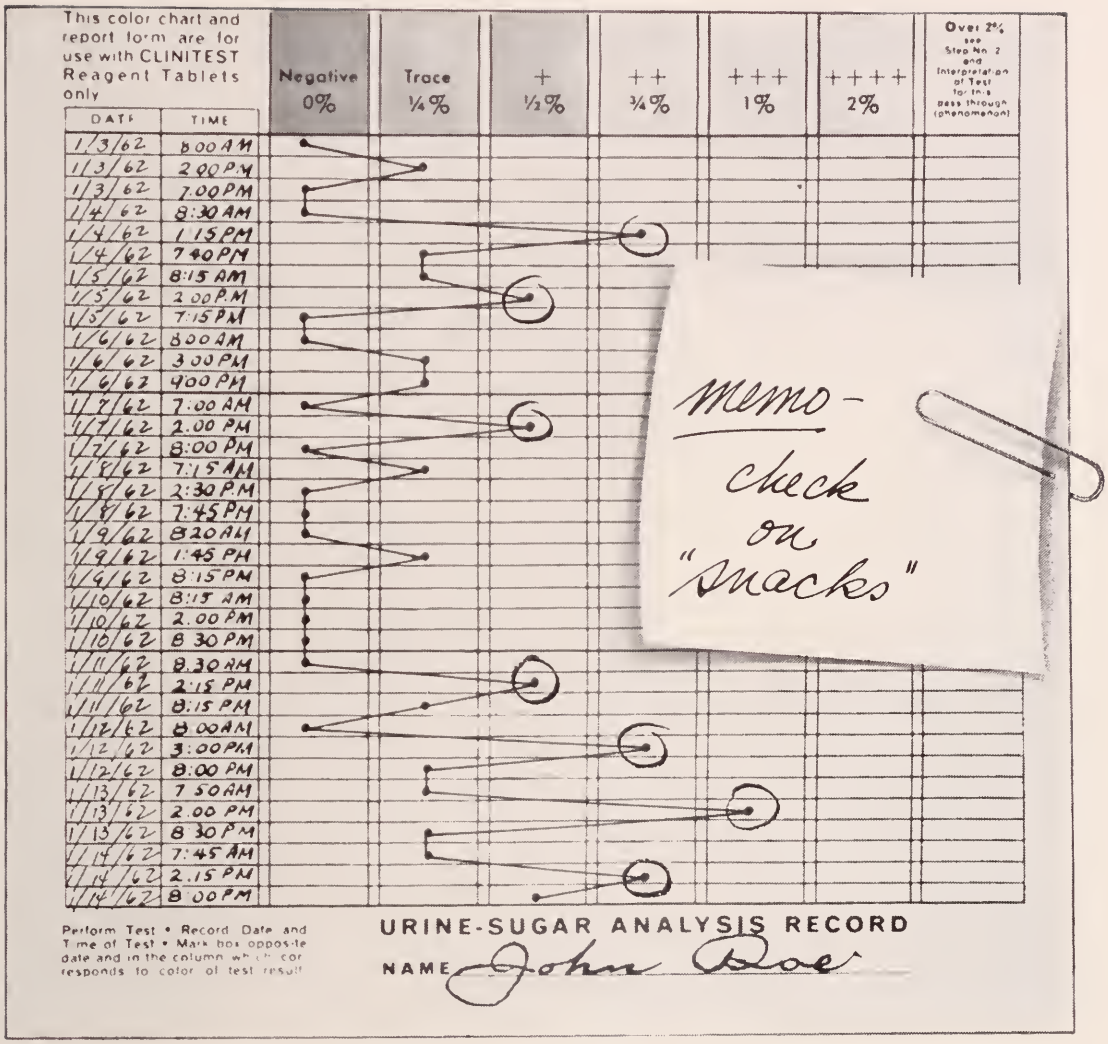
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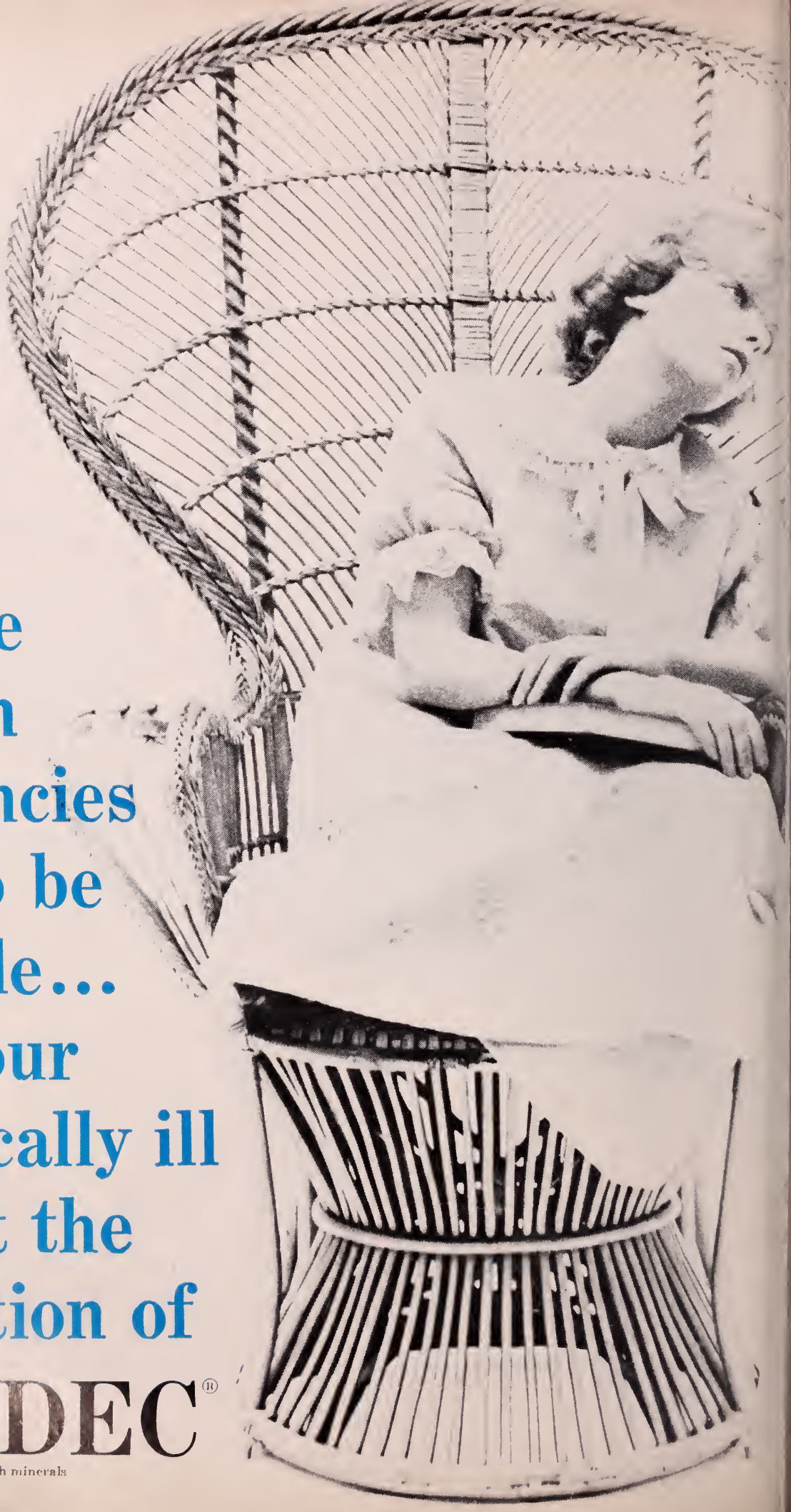
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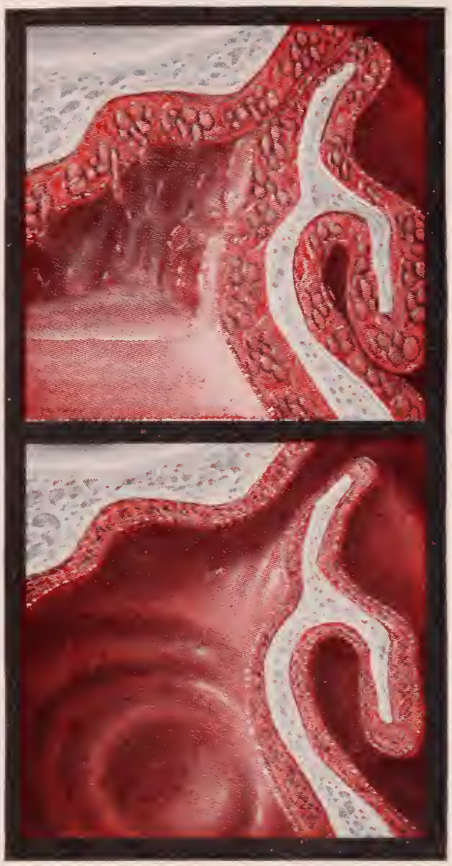
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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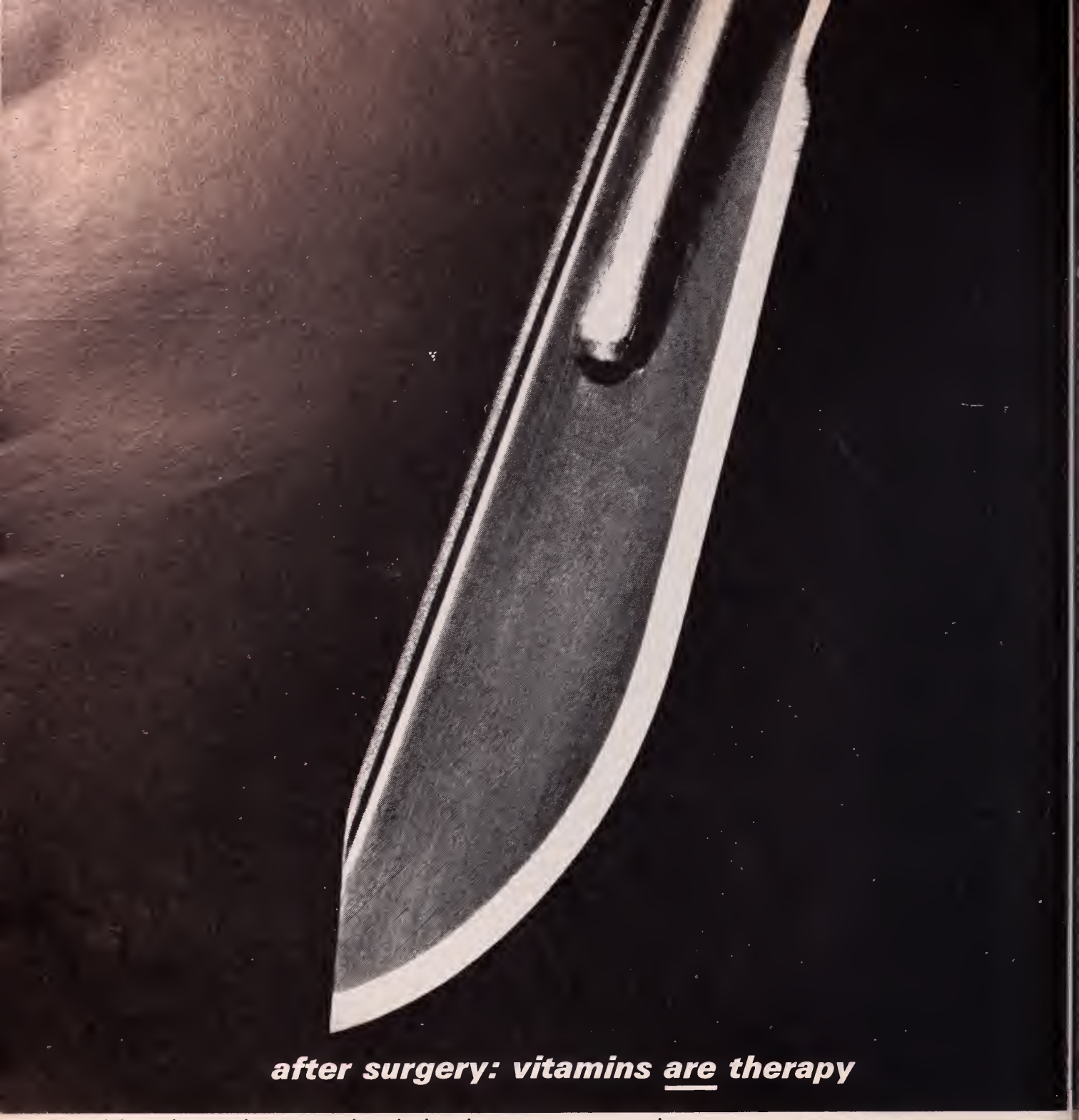
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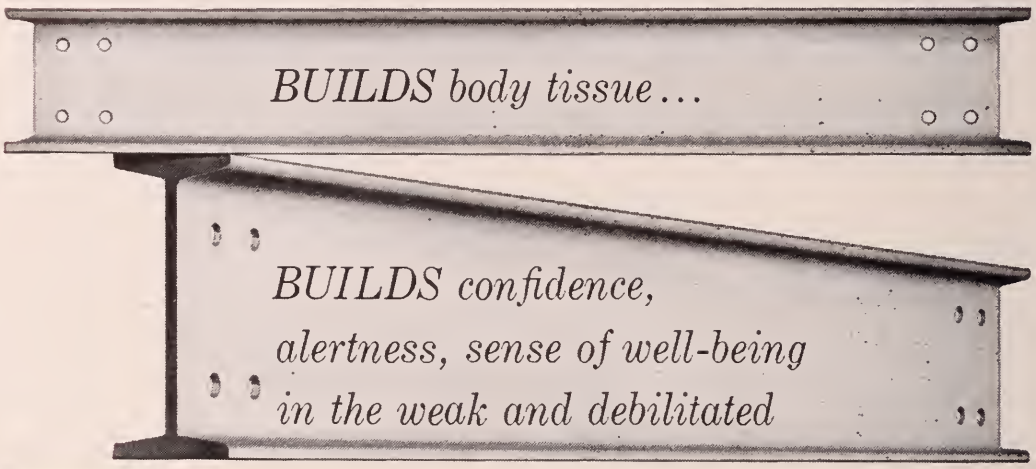
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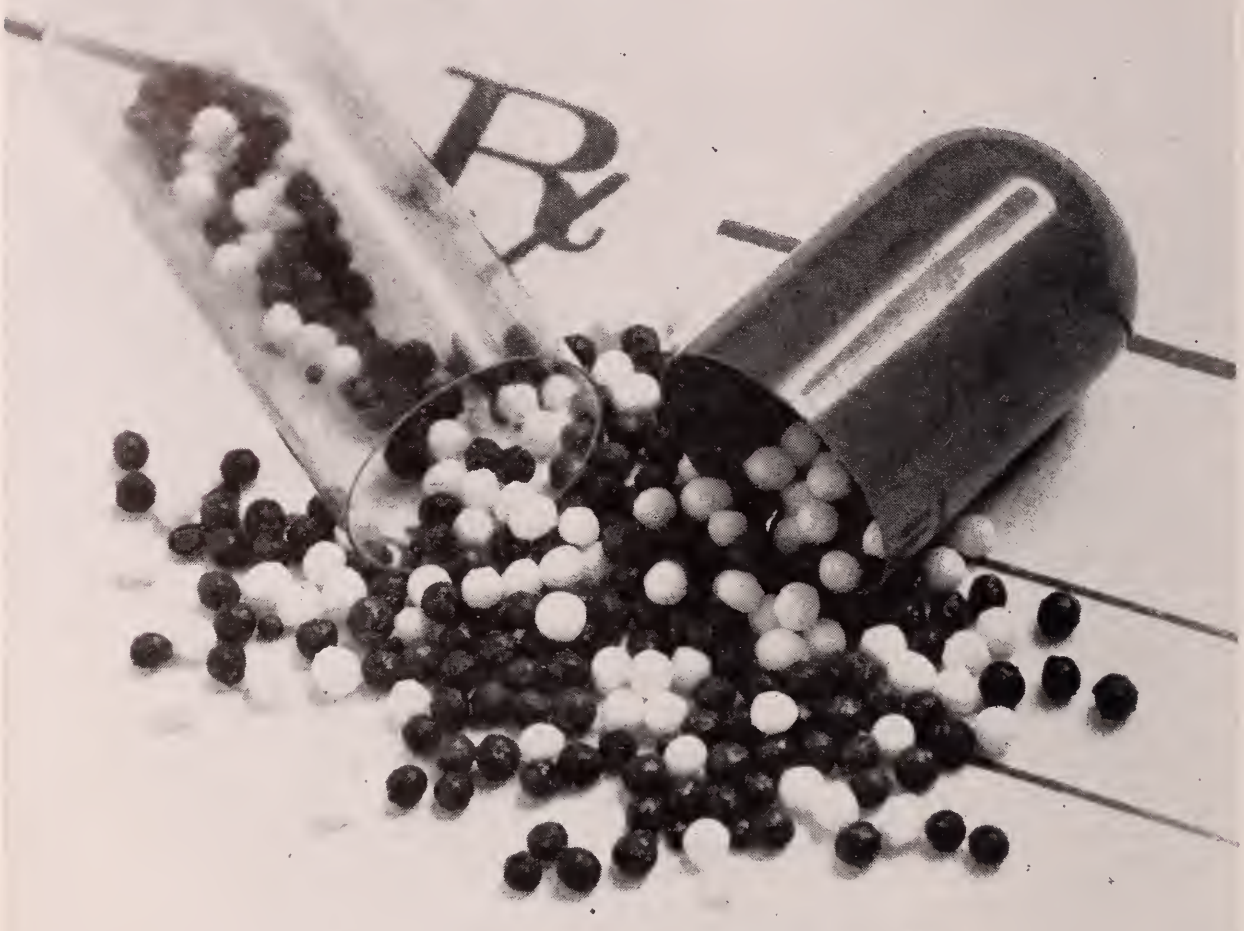
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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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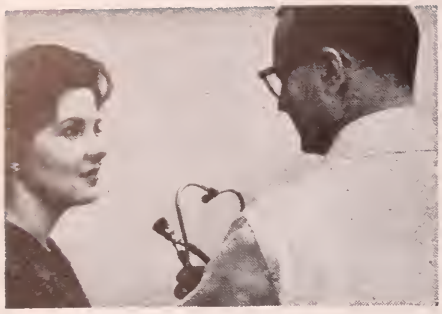
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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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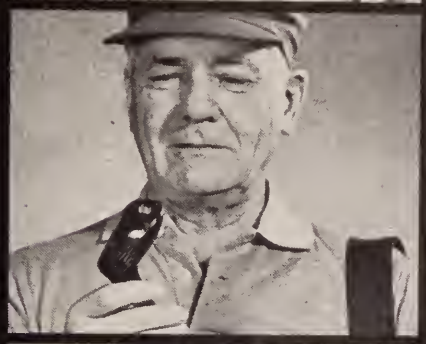
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Snake Bite Treatment and Complications

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MIAMI

The treatment of snake bite has been a controversial problem for years. Thirty to 40 thousand people die each year in the world from snake bite.[1] Russell[2] estimated that there are about a thousand poisonous snake bites each year in the United States. It has been further estimated that from 10 to 20 deaths occur each year from snake bite in the United States.[1] Approximately three persons die each year from snake bite in Florida.[3]

Type of Snake—Where Found

There are two families of snakes in the United States which are considered poisonous to man. These are: The Crotalidae (pit vipers) and Elapidae (coral snakes). Seven varieties of poisonous snakes are found in Florida. The family name, scientific name and general range are noted here:[4]

Family: Crotalidae (pit vipers)	Range
Eastern Diamond Rattlesnake Crotalus Adamanteus	Throughout state
Canebrake Rattlesnake Crotalus Atricaudatus	Northern Florida south to Alachua County
Dusky Pigmy Rattlesnake Sistrurus Miliarius Barbouri	Throughout state
Southern Copperhead Ancistrodon C. Contortrix	Northern Florida, Liberty and Gadsden counties only
Eastern Cottonmouth Ancistrodon P. Piscivorus	Throughout state
Eastern Coral Snake Micrurus F. Fulvius	All Florida except southern tip of peninsula
South Florida Coral Snake Micrurus Fulvius Barbouri	Extreme Southern Florida

It has been estimated that rattlesnakes are responsible for 85 per cent of the deaths from snake bite in Florida. The cottonmouth is the second most deadly offender. Few deaths result from bites by pigmy rattlesnakes, copperheads or coral snakes. It has been estimated further that rattlesnakes account for about 60 per cent of all snake bites occurring in Florida, cottonmouths for about 20 per cent, copperheads for 2 per cent and coral snakes for 2 per cent. The remaining 16 per cent are unidentified.[4]

Identification

Several characteristics help identify the poisonous snakes in the Florida region. The coral snake is a small (1 to 2 feet), brightly colored reptile, having black, red and yellow stripes. It is often confused with the scarlet king snake, but need not be if it is remembered that the coral snake always has a black snout followed by the ringed markings, while the scarlet king snake has a red snout. There is an old saying, "Red and black, good for Jack; red and yellow, kill a fellow," which refers to the distribution of the coral snake's stripes. Pit vipers (rattlesnakes, et cetera) are identified by the "pit" which is present on the lateral side of the head. The mouth of the pit vipers may be pried open and the fangs identified protruding from the maxillae. In the rattlesnake, the famous rattle is usually present and will serve as an identifying feature.*

Diagnosis

When the physician is faced with a likely victim of snake bite, he must decide if venenation (poisoning) has occurred. Parrish[5] has suggested the following chart as an aid in diagnosis. Coral snake bite will be discussed separately.

*Department of Surgery, University of Miami School of Medicine
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*For more complete information, the reader may write the Florida Wildlife Association, Tallahassee.

Characteristic	Pit Viper Venenation	Other Snake Bite Without Venenation
Local swelling or edema	Present, progressive	None to very minimal
Local erythema	Present, progressive	None to very minimal
Local pain	Intense, persistent	Minimal, transient
Fang puncture	Present	Usually absent
Symptoms of shock, giddiness, weakness, syncope, hypotension	May be present	Absent
Nausea, vomiting and diarrhea	May be present	Absent
Muscular twitching	May be present	Absent
Numbness and paresthesia	May be present	Absent
Motor or respiratory paralysis	May be present	Absent

Sequelae	Pit Viper Venenation	Other Snake Bite Without Venenation
Infection	Common	None
Gangrene	Common	None
Sloughing	Common	None
Hemorrhages	Common	None
Anemia	Common	None
Atrophy	Common	None

In cases of pit viper venenation, the onset of symptoms is rapid, and swelling, pain, erythema and other indications may be noted within minutes. Certainly, observation of the patient for one hour will eliminate the likely possibility of venenation except in the case of coral snake bites.

Factors In Snake Bite

Certain factors alter the severity of snake bite and are important in the ultimate outcome of venenation. Klauber[6] listed the following factors which enter into the outcome of rattlesnake bite. They may be considered true of pit viper bites in general:

- Age, size, vigor and health of the victim
- Allergy complex of the individual
- Psychological condition and nature of the victim
- The site of the bite
- The nature of the bite
- Protective clothing
- Number of bites
- The length of time the snake held on
- The extent of anger of the snake
- The condition of the fangs and venom glands
- The species and size of snake
- The presence of various microorganisms in the mouth of the snake
- The nature of the first aid

The literature is abundant pertaining to the chemical properties and nature of snake venom; yet no one can say for certain exactly how the venom of the pit viper kills. The venom of North American pit vipers is primarily proteolytic and hematoxic, whereas the venom of coral snakes is primarily neurotoxic in action. For more of the chemical properties of snake venom, the reader is referred to the book, "Venoms," published by the American Association for the Advancement of Science in 1956.

Complications

When dealing with snake bite victims, a variety of signs may be seen at one time or another. Among these are the following:

- Local swelling
- Local pain
- Vomiting
- Discoloration
- Shock
- Fever
- Diarrhea
- Anemia
- Abdominal pain
- Sanguinolent blebs
- Serous blebs
- Quincke's edema
- Nausea
- Toxic lymphangitis
- Weakness
- Cold perspiration
- Retention of urine
- Skin hemorrhages
- Restlessness
- Bradycardia
- Hemorrhages in the mucous membrane
- Disturbances in swallowing
- Hematuria
- Ecchymoses

Late sequelae are: Lymphedema, contracture (of Dupuytren's type), peripheral neuritis, gangrene and tissue slough.

Opinions vary widely in the treatment of snake bite. Unfortunately, no one person has a large series of cases which he has graded, treated and followed up. Rather than on vast personal experience, the recommendations for treatment are made by most authors on minimal personal experience, review of the literature and experimental evidence in animals other than man. Personal inquiry with a group who have collectively treated, or have been an active consultant in over 200 cases of snake bite, has provided much valuable information in the preparation of this paper. This group does not agree necessarily with the proposed outline of treatment, but their experience has been important in formulating the protocol which is to follow.

Treatment

Treatment of snake bite may be divided into two phases: (1) First aid, and (2) Medical. As in any emergency situation, what is initially accomplished in first aid may greatly alter the outcome.

First Aid

First aid treatment of snake bite is most important and, if conducted properly, may prevent much of the morbidity and reduce the mortality. Most people with knowledge of the treatment of snake bite think that individual cases are overtreated.

1. Do not panic. This is important for both the victim and companions, if present. Try to identify the snake if at all possible. Only 3 per cent of snake bites (poisonous) are ultimately fatal.[8]

2. Immobilize the limb. If possible, the affected limb should be placed at rest. It is very important that the victim does not run. If no one is present to carry the victim, he should walk even if it takes extra time.

3. Tourniquet. A venous occlusive tourniquet may be placed proximal to the bite, if the bite has occurred on an extremity. This tourniquet should occlude the venous drainage of the involved area and should not be occlusive of the arterial blood supply. At 30 minute intervals the tourniquet should be loosened for 30 seconds. The tourniquet must be applied within one to five minutes to be maximally effective and, of course, shorter time intervals are more effective as far as dissemination of venom is concerned. At the present time, the United States Armed Forces is conducting extensive work relative to the efficiency of the tourniquet. The efficiency is seriously questioned by many.

4. Incision and suction. As soon as possible, two incisions should be made lateral to the fang marks and parallel to the body. Cruciate incisions over the fang marks are acceptable. These incisions should be made with instruments as clean as can be obtained. The venom disseminates very rapidly and any delay beyond 15 minutes has allowed the dissemination of a good portion of the venom into the surrounding deep lymphatics and tissue spaces.[9] The incisions should be about one-fourth to one-half inch long and one-eighth inch deep or just through the skin. Incisions extending into muscle mass only cause more rapid dissemination. Either cup or oral suction may be used.

5. Do not give alcohol. If fluids are given orally, coffee may be used.

6. Antivenin. Antivenin should be administered by qualified personnel only. Any type of serum reaction is most difficult to deal with away from prompt medical attention. If someone is present who is capable of interpreting skin tests and realizes the inherent dangers of antivenin, then one vial may be given intramuscularly around the bite site, except in case of a bite on the finger or toe where additional fluid may impair the circulation by increasing the amount of edema. A layman should never give antivenin.

7. Ice bags may be applied to relieve pain. Do not immerse the limb in ice. McCollough[9] has a series of 54 serious extremity bites treated with refrigeration of which 36 ultimately came to major amputation. On this basis, cryotherapy is not recommended.

8. Transportation. Only incision and suction within 15 minutes of the bite should supersede rapid, orderly transportation. All efforts should be made to have the patient seen by a physician within one hour following the bite.

Medical

Few snake bites reach medical attention until at least 30 minutes have elapsed. If the victim arrives at any time prior to one hour after the bite, the use of the tourniquet, incision and suction may be used. It must be pointed out that suction should be careful and gentle if venom is not to be disseminated. After one hour, the use of incision and suction is questionable and to be determined by personal preference. It is urged

strongly, however, that mutilating incisions be avoided and the use of the scalpel after one hour be considered carefully before proceeding. Incisions should never be used when vital structures, such as tendons, nerves and arteries, might be damaged.

1. Bed rest and immobilization. Most poisonous snake bites require the patient to be admitted to the hospital. The patient is placed in bed and given reassurance. If the bite is located on an extremity, it should be elevated above the level of the body after the antivenin has been given. This tends to decrease pain and facilitate treatment. Ice bags may be used until antivenin has been given.*

2. Antivenin. The single most important facet of medical treatment is antivenin. A skin test for sensitivity should be performed as soon as the patient enters the hospital. While awaiting the necessary 15 minutes for the result, steps four, five and six should be completed if possible. Only the treatment of shock should delay the use of antivenin, and it should be used in large doses (four or five vials) initially. In children, the dosage is as large, if not larger, due to the venom/blood volume ratio. The route of administration is variable. It may be given intramuscularly or intravenously. If the patient is quite toxic, at least two thirds of the medication should be given intravenously and the remaining one third given intramuscularly adjacent to the site of the bite. As mentioned under "First Aid," the intramuscular injections should not be made in small members of the extremities. A small amount may be given around the site (1 or 2 cc.), but large volumes are to be avoided. In severe toxicity, a total of 10 or more vials may be necessary. These should be administered at approximately two hour intervals and may be given intravenously.

3. Laboratory work. This should consist of urinalysis, hemoglobin determination, hematocrit reading, white blood cell count, differential count, blood urea nitrogen and type and crossmatch for at least 1,000 cc. of whole blood. In a severe bite, determination of the hemoglobin and hematocrit levels should be repeated every four to six hours for the first 48 hours because anemia may develop rapidly. Blood urea nitrogen, urinalysis and white blood cell count should be repeated at 48 and 96 hours, unless otherwise indicated. Follow up laboratory work as indicated.

4. Intravenous fluids. Intravenous administration of 5 per cent dextrose in water should be started immediately, using a blood administration set and, if the patient is in shock, a suitable vasopressor should be used. The first 24 to 48 hours are the critical period. Whole blood should be given as indicated by the hemoglobin and hematocrit levels. Although it is reported that the blood of the victim is difficult to type and crossmatch after a few hours, no experimental or clinical evidence was found to support this claim.

5. Cortisone, ACTH and hydrocortisone. Various combinations of these drugs may be used as an adjuvant to therapy. They are not, however, a substitute for antivenin. Some now believe that cortisone will help avoid anaphylactoid shock or symptoms associated with the antivenin.[10] Hydrocortisone, 100-200 mg. intravenously every four to six hours for the first 48 hours, is the usual dose. Oral cortisone derivatives should be used as soon as tolerated. They should be discontinued in decreasing dosages if used for a prolonged period of time.

6. Sedatives. The chief source of restlessness in the pit viper bite is pain. Narcotics should be used for pain and phenobarbital for sedation.

7. Tetanus toxoid. Although the use of tetanus antitoxin is questionable, it is wise to give 0.5 cc. of tetanus toxoid. Fatal cases of tetanus have been reported subsequent to snake bite in the past.[11] For medicolegal reasons, tetanus antitoxin should be used in persons not previously immunized.

8. Antibiotics. With any severe bite there is almost invariably an infection. An immediate culture is advisable and this should be repeated as necessary.

9. Warm Epsom salts soaks. Purposely this recommendation has been left last in order that it may be discussed. It is not, at present, a part of the treatment protocol, but may find a later place in the treatment of snake bite. While no reference to warm soaks could be found, personal communications[12] indicate that, when used one or two hours after the initial injection of antivenin, a uniform decrease in the amount of tissue necrosis occurred. No increase in toxicity was observed with warm soaks. While no experimental evidence exists supporting this method, it may be justified to use this attempt to reduce the amount

*See step number seven under "First Aid" and step number nine under "Medical" treatment.

of tissue necrosis obtained so frequently with snake bite.

Coral Snake Bites

As stated previously, coral snake bites account for approximately 2 per cent of all snake bites in Florida.[4] The venom which is chewed into the victim is primarily neurotoxic rather than a locally necrotic agent. The signs and symptoms of coral snake bite, therefore, differ from those of the pit viper bite. The symptoms of coral snake bite are as follows:[13]

Local pain
Motor paralysis
Muscular twitching
Inability to speak clearly
Salivation
Numbness
Respiratory difficulty
Ptosis of eyelids

Haast,[14] who has been bitten some 35 times by snakes producing neurotoxic venom, pointed out that there is little to no swelling with the coral snake or the cobra bite. He further stated that the local pain may be delayed and may not appear until some two hours following venenation. Indeed, the intervening two hours may actually find the patient euphoric and feeling "sharp" comparable to the "lift" obtained with amphetamines. These factors greatly alter any early assurance to the patient that he has suffered no ill effects from the bite of the coral snake.

The chief cause of death from the coral snake bite is respiratory paralysis and, therefore, the treatment is largely the same as supportive treatment for bulbar polio. This consists chiefly of:[14]

Tracheostomy
Oxygen therapy
Respirator
Antibiotics
Tetanus toxoid
Antivenin

Coral snake antivenin is now available and is produced in South America. It is produced in horses and, therefore, the usual horse serum precautions are to be taken. Dosage range is 20 cc. to 120 cc. and should be given subcutaneously or intramuscularly. Repeat dosage may be given in four to six hours as required.[15]

This antivenin is available at the following locations: Lakeland General Hospital, Lakeland; Winter Haven Hospital, Winter Haven; Jackson Memorial Hospital, Dade City; and Florida Baptist Hospital, Plant City.[16]

The Florida State Board of Health lists the following locations for coral snake antivenin: Hillsborough County, Tampa Emergency Squad, Tampa; Indian River County, Indian River Memorial Hospital; Escambia County, Baptist Hospital, Pensacola; Dade County Health Department; Orange County Health Department; Palm Beach County Health Department; and Florida State Board of Health.[15]

No report of the successful use of coral snake antivenin was found, but this is no contraindication to its use since coral snake bites are rare. While coral snake antivenin should be used, in an emergency cobra antivenin may be used with success.[11] Cobra antivenin is available from Mr. William Haast, Miami Serpentarium. The use of incision and suction or excision offers little or no delay in the onset of systemic effects.[14]

Summary

In summary of the treatment of snake bite, the treatment of pit viper venenation is:

First Aid: (1) Attempt to reduce pain. (2) Tourniquet. (3) Immobilization of limb. (4) Incision and suction as soon as possible. (5) Antivenin if qualified person is present. (6) Ice bags. (7) Proper transportation.

Medical: (1) Depending on time, incision and suction. (2) Bed rest and immobilization. (3) Antivenin. (4) Laboratory work including type and crossmatch. (5) Intravenous fluids. (6) Cortisone and/or derivatives. (7) Sedatives. (8) Tetanus toxoid. (9) Antibiotics.

Coral snake bite treatment has been covered briefly: (1) Tracheostomy. (2) Oxygen therapy. (3) Respirator. (4) Antibiotics. (5) Tetanus toxoid. (6) Coral snake antivenin or cobra antivenin.

Conclusion

This paper has covered the problem of snake bite as seen by the Florida physician. Great detail of many of the controversial areas has been avoided in an attempt to give the practicing physician a workable protocol. It is to be emphasized that the physician in a snake bite case is involved in one of the most emotional problems of medicine. The majority of the lay public believes that 100 per cent of poisonous snake bites are ultimately fatal. Only by thorough knowledge of the problem may the physician dispel this belief.

It must be emphasized that no one protocol of treatment will satisfy every physician. Most physicians must rely on textbooks for their knowl-

edge of the treatment of snake bite, but those who have treated a severe snake bite know that the victim may well be at the brink of death and that treatment leaves much to be desired.

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1000 Northwest Seventeenth Street (Dr. Farrell). Clark-Terrace Apartment 6, Savannah, Ga. (Dr. Evans).

Fluphenazine (Prolixin) as an Antiemetic Agent in Children

LEWIS T. CORUM, M.D.
TAMPA

Emesis is such a common symptom in children that its sporadic occurrence may be largely disregarded. Persistent vomiting in children, however, may be a matter for considerable concern not only because it may signify the presence of some serious underlying illness, but also because, in uncontrolled vomiting, severe disturbances in the normal fluid and electrolyte balance of the body develop much more rapidly in children than in adults.[1] Though vomiting should be regarded in every case as a symptom and therapeutic measures should be directed at its cause, the control of vomiting frequently becomes of vital importance in the care and treatment of pediatric patients.

Within the past few years several drugs have been developed and introduced to control nausea and vomiting. Among those which have been widely used are the phenothiazine derivatives, such as chlorpromazine, trifluprom azine and promethazine. These compounds presumably act by depressing the chemoreceptor trigger zone for emesis[2] and are highly effective in controlling nausea and vomiting from a variety of causes.[3-5] Fluphenazine (Prolixin*), with which the present report is concerned, is a trifluoromethyl-hydroxyethyl piperazinepropyl derivative of phenothiazine. In laboratory studies, fluphenazine has displayed antiemetic activity 200 times as potent as that of chlorpromazine and 20 times as potent as that of trifluprom azine.[6] The apparent effectiveness of the drug in minute doses is of considerable interest and has led to its trial here to control emesis in pediatric outpatients. Fluphenazine has proved to be almost 100 per cent effective in controlling vomiting in a small series of patients when given as a single rectal suppository. A brief account of my experience with the drug in this trial follows.

*Prolixin is a Squibb trademark.

Methods and Materials

Thirty-five pediatric patients were treated with fluphenazine to control vomiting associated with acute infections of the upper respiratory or the gastrointestinal tract. The youngest of these children was six months old; the oldest was seven years of age. Twenty-four were males and 11 were females. All had had recurrent attacks of vomiting for periods varying from one and one-half to 24 hours prior to treatment. Some of the patients had fever; the majority complained of pains in the stomach or chest. Three of the children were asthmatic, four presented signs and symptoms of bronchitis, one child had pneumonia, and another complained of earache.

Fluphenazine was administered as a rectal suppository to all of the 35 patients, each suppository containing 0.25 mg. or 0.5 mg. of the drug in a water-miscible base of polyethylene

glycols which was readily soluble in body fluids. In every case but one, only one treatment was given. The single exception was a child one year of age who required two treatments before symptoms ceased. The usual dose was 0.25 mg. of fluphenazine though in eight cases 0.5 mg. of the drug was given, generally to older children of five years of age or more, but in one case, a patient two years old, the higher dose of the drug was given because of the severity and duration (13 hours) of symptoms.

Results

Vomiting was effectively controlled in 31 of the 35 patients treated with fluphenazine rectal suppositories. Relief of symptoms was apparently immediate and complete in 28 of the 31 patients because emesis did not recur in any of these patients after the administration of a single suppository containing the drug. In two additional cases, there were one or two minor episodes of vomiting after the initial treatment, but these symptoms ceased within a few hours without a second treatment. Emesis persisted in another patient, however, until the following day when symptoms promptly disappeared following the administration of a second suppository. Fluphenazine appeared to be especially beneficial in the three asthmatic patients of this series. Not only was vomiting completely abolished in these patients, but the anxiety that accompanied the acute attacks of asthma was relieved. Moreover, the administered medication appeared to enhance the effectiveness of the epinephrine which was given concomitantly to relieve these asthmatic paroxysms.

Four of the 35 patients showed no apparent response to the administered fluphenazine suppository since emesis persisted in each of these patients. All were acutely ill, three with gastroenteritis and one with pneumonia, and all were hospitalized for further therapeutic measures.

Fluphenazine, as administered, was well tolerated by all of the patients in this series. No side effects were seen in any patient and no local reactions, such as itching, burning, or rectal discomfort, were observed.

Discussion

Fluphenazine would appear to be a highly effective antiemetic drug which, when administered rectally in single doses of 0.25 mg. or 0.5 mg., will dispel vomiting in a high percentage of pediatric patients. In this small series, a single suppository containing a minute amount of the drug was almost 100 per cent effective in controlling emesis. The drug is rapid in action, easy to administer, and well tolerated by children of all ages. Altogether, I was well pleased with the medication.

Summary

Thirty-five pediatric patients with persistent vomiting associated with acute infections of the upper respiratory or the gastrointestinal tract were treated with fluphenazine administered as rectal suppositories in a water-miscible vehicle of polyethylene glycols. Each suppository contained 0.25 mg. or 0.5 mg. of the drug. The usual dose was a single suppository containing 0.25 mg. of fluphenazine. Relief of emesis was obtained in 31 of the 35 patients, the relief being apparently immediate and complete in 28 of the 31 patients since no further episodes of vomiting occurred. In 30 patients, a single suppository was effective, while one patient required the administration of a second suppository on the following day before symptoms disappeared. No apparent response was evident in the remaining four patients.

No side effects were seen, and no local reactions were observed such as itching, burning or rectal discomfort. The medication was especially beneficial in three asthmatic patients. The drug not only relieved vomiting in these patients, but it also dispelled the anxiety which accompanied the attacks of asthma.

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VOLUME XLVIII
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Multiple Carcinoma of Gastrointestinal Tract

Report of a Case and Its Management

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CORAL GABLES

A case is reported in which carcinoma of the gastrointestinal tract involved four separate sites, the cecum and ascending colon, the transverse colon, the rectum and the stomach. The management of this case, which so far has included a total colectomy with resection of the rectum and terminal ileum, two resections in the pelvis and a gastrectomy, is described.

Report of Case

A 55 year old white woman was admitted to the hospital in August 1958 because of failing health, severe anemia, diarrhea, and a growing mass in the right side of the abdomen of four months' duration. A barium enema study revealed an extensive carcinoma of the hepatic flexure and right transverse colon with polyps. There was a history of left oophorectomy.

On examination, the patient looked like she was in the terminal stage of carcinoma; she was emaciated, poorly nourished, pale, and unable to support herself on her feet. The right half of the abdomen was occupied by a large fixed mass extending from the liver to the pelvis. Ulcerating infiltrating carcinoma was present in the lower portion of the rectum.

After a rapid preparation, including transfusions, the patient was subjected to an exploratory operation. Three separate carcinomas were found. The one involving the cecum and ascending colon was by far the largest; the second one was in the transverse colon and the third one in the rectum. Extensive involvement of the mesentery was noted, by contiguous and also by lymphatic spread. I performed a total colectomy with abdominoperineal resection and ileostomy in one stage. The pathologic diagnosis was adenocarcinoma of the colon and rectum with polyps.

Postoperatively, the patient did extremely well; her health rallied, and the blood picture became normal. After an initial period of adjustment to an ileostomy, she went back to work and led an active normal life.

In June 1959, 10 months later, her health started to deteriorate, and a rapidly growing abdominal and pelvic mass appeared. Rather than give up her case as one of hopeless terminal carcinoma, I decided to perform an exploratory operation again. I resected a large abdominal mass arising from the region of the right ovary and displacing the small bowel and stomach. A search of the stomach and small bowel gave negative results. Incidentally, resection of the metastasis was made easier by the absence of the large bowel and rectum. There was no left ovarian remnant. The pathologic diagnosis was metastatic adenocarcinoma of the right ovary. Again the patient rallied after the operation, gained weight, and went back to work.

Fifteen months later, there was recurrence of an abdominal mass. Her health began to fail, and the hemoglobin started to drop. At operation the third time I found extensive metastasis in the pelvis with one large tumor arising from the region of the excised left ovary. A pyloric gastric ulcer and a prepyloric carcinoma next to it were palpable in the wall of the stomach. After resecting the pelvic mass, I performed a subtotal gastrectomy, removing three fourths of the stomach and the first part of the duodenum, anastomosing the gastric remnant to the jejunum. Except for the ulcer, the mucosa and serosa of the stomach were intact. The pathologic diagnosis was metastatic adenocarcinoma of the left ovary and carcinoma of the stomach.

The patient was discharged seven days after the operation, following an uneventful postoperative course. At the present time she has had a total colectomy with resection of the rectum and terminal ileum, two resections in the pelvis and a gastrectomy. She is able to maintain good nutrition in spite of the absence of the rectum, colon, part of the ileum, most of the stomach, and a defunctionalized duodenum.

Comment

Rectal examination, sigmoidoscopy, and a barium enema study should be carried out on patients with carcinoma of the colon in an effort to get a picture of the whole colon, and, to judge from the case presented, even a gastrointestinal series in selected cases is worth while.

At operation a search for additional foci of carcinoma in the colon should be made as the incidence of multiple carcinoma is 4 per cent to 8 per cent.

As a prophylaxis to subsequent ovarian metastasis, bilateral oophorectomy is a worth while procedure, to be performed in conjunction with resection of the colon or stomach for the primary lesion. There is, as yet unexplained, a peculiar strong affinity of gastrointestinal carcinoma for the ovaries.

When confronted with ovarian carcinoma, the surgeon should always palpate the stomach and colon for the primary site.

Recurrence of abdominal carcinoma, whether expected or not, should not be considered as a terminal phase. An attitude of hopelessness is not justified in many instances.

The presence of metastasis, whether local, regional, or distant, should spur the surgeon to remove rather than deter the surgeon from removing any gross evidence of carcinoma. This policy adds up to the longevity and comfort of the patient.

Summary

Until someone discovers a better method of treatment of carcinoma of the gastrointestinal tract, one's guide should be: (1) Diagnose it early. (2) Treat it early. (3) If it metastasizes, resect it. (4) If it recurs, resect it again.

2506 Ponce de Leon Boulevard.

Prevention of Hemorrhage After Tonsillectomy and Adenoidectomy in Children

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The purposes of this paper are (1) to confirm that postoperative hemorrhage from tonsil fossae can be completely eliminated and (2) to report on the incidence and the analysis of certain factors affecting hemorrhage from the adenoid area. All the combined tonsillectomy and adenoidectomy operations performed on children by one of us (CDB Jr.) during 1959 and 1960 are used for this study. There were 298 boys and 236 girls for a total of 534.

Operative Technique

The patients were all given Luminal sodium and scopolamine before operation. Anesthesia was by open drop induction, using vinyl ether and diethyl ether with maintenance of anesthesia by ether vapor in oxygen from a Foregger or Heidbrink gas machine. The Davis type mouth gag was used, and the patients were placed in the head-down position with the operator seated at the head of the table. The adenoids were removed first. If they were large, the central mass was removed with an adenotome, after which the remaining tissue was removed with an adenoid curette. If the adenoid tissue was not large, only the curette was used. Small fragments that were present near the level of the free edge of the soft palate were often removed with biting forceps. Regular adenoid sponges were then packed tightly into the nasopharynx and left in place while the tonsillectomy was performed.

The tonsils were removed by incision of the mucosa of the anterior pillar, upper pole and posterior pillar with a knife blade followed by blunt dissection with the smooth-edged Hurd dissector down to the inferior pole, which was severed with the Eaves wire snare. Without regard to specific bleeding points, the tonsil fossae were sutured in such a manner as to obliterate them, rather than merely close their edges. This technique was first described by Emerson[1,3] in 1952. Three separate sutures of size 0 chromic catgut on a ½ round atraumatic needle were routinely taken in each tonsil fossa. The needle passes from the posterior pillar to the anterior pillar just under the surface for the entire width of the exposed fossa bed. Usually the first suture, at the inferior pole, cannot be made in one pass of the needle. The needle is brought out about midway of its proposed tract, then re-entered near this exit, finally to come out near the free edge of the arterior pillar before the surgeon's knot is tied. This procedure puckers the tonsil fossae in such a way as to leave no dead space. Rarely some bleeding can be seen after the three sutures have been tied. If so, one or two additional sutures are taken until the bleeding has completely stopped and no unclosed gaps are present. The sponges are then removed from the nasopharynx and the area observed for a few minutes for evidence of bleeding. If little or no blood wells up in the nasopharynx, the operation is ended. If blood repeatedly fills the nasopharynx after two or three suctionings, a postnasal pack is inserted.

After the children are sent to the recovery room or back to their beds, they are observed for bleeding from the nose or mouth. If more than a small amount of bloody drainage is seen, or if oozing persists longer than 20 or 30 minutes, some type of medication considered to be helpful in coagulating blood or arresting hemorrhage is given. Our routine has been to give 1 cc. of Adrenosem intramuscularly first. If bleeding persists, we next give 2 cc. of Koagamin intramuscularly. If more medication is needed, 20 mg. of Premarin is given intramuscularly. If bleeding is not controlled by these medications, a postnasal pack is inserted if one is not already in place, or other measures are resorted to, such as blood transfusion or return to surgery for more sutures or a new pack.

Discussion

Postoperative bleeding is usually defined as primary when it occurs in the first 24 hours and secondary thereafter. There have been many studies and reports about secondary hemorrhage

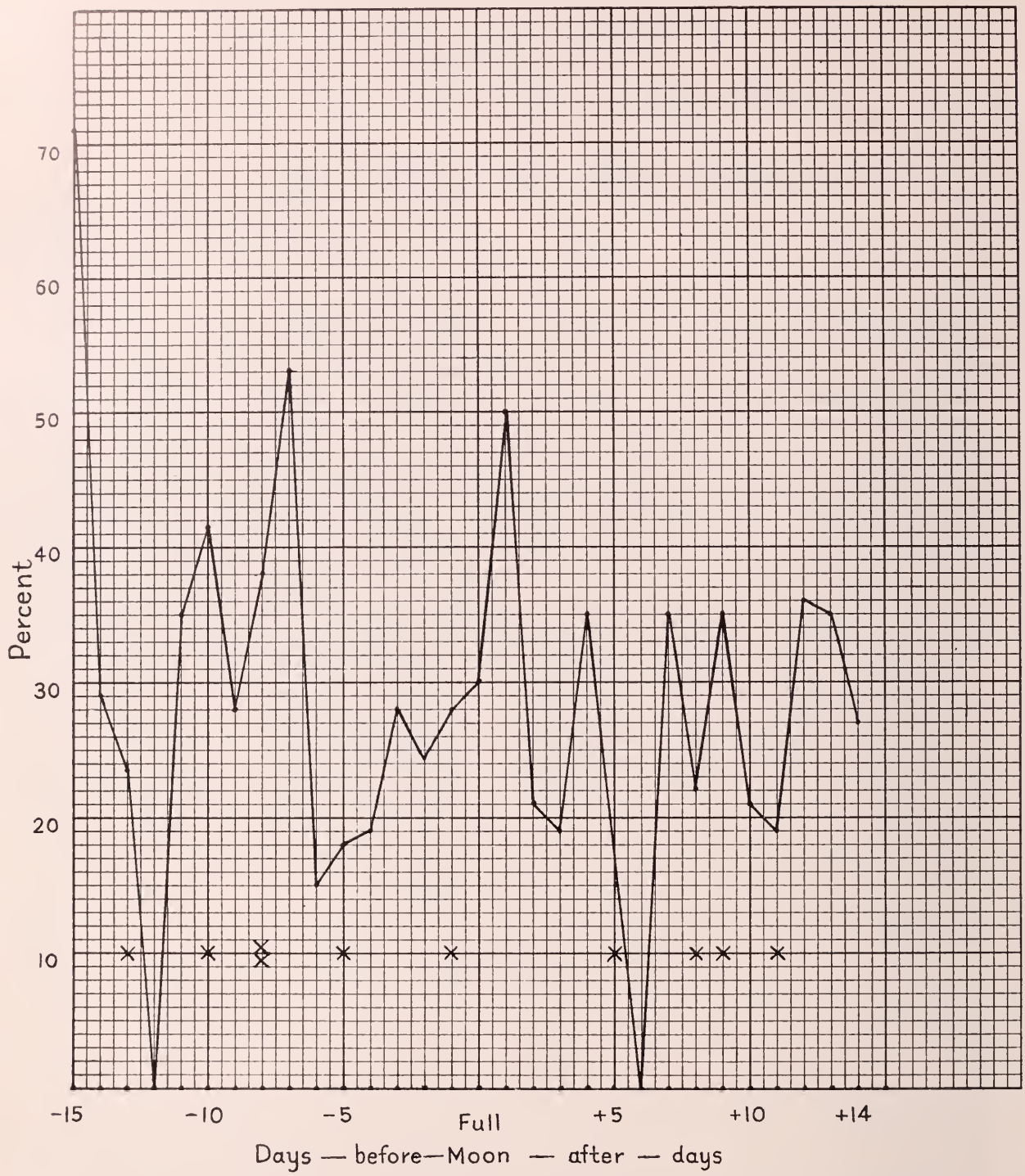


Fig. 1.—Relation of moon phases to postoperative bleeding after tonsillectomy and adenoidectomy. Each point represents per cent of patients requiring postnasal pack or coagulant medication after surgery. X indicates dates of moderate or severe bleeders.

following tonsillectomy and adenoidectomy, but little information is available covering the prevention and treatment of primary hemorrhage. In the largest group of cases reported in the recent medical literature, 19,754 operations were analyzed.[1] Primary bleeding occurred in 4.6 per cent and secondary bleeding in 1.4 per cent. In another study involving 1,035 cases, primary bleeding was reported in 4.3 per cent, and secondary bleeding occurred in another 4.3 per cent.[5] Still another report on 2,739 operations showed 3 per cent primary hemorrhages and 6 per cent secondary hemorrhages.[6] Primary hemorrhages are said to be more frequent from the adenoid fossa and secondary hemorrhages more common from the tonsil fossae.[4,7]

Natural conditions that have been considered as possible revelant factors in postoperative bleed-

ing are barometric pressure,[5] nationality, age, race, sex and coloring.[4] The only one of these factors that seems to bear any relation to bleeding is barometric pressure, and this was found to be not very important.[5] It has also been reported that bleeding is more likely to occur during the period near the full moon of each month.[8] Figure 1 shows the percentage of patients in this present series who had any primary hemorrhage or who required a postnasal pack on the various days of the moon's phases. It can be seen that in our series no correlation exists.

Factors associated with the patient's health have some bearing on bleeding. It has been reported that the presence of mucopurulent material in the nose or throat, badly decayed teeth, and large tender cervical nodes increase the incidence of postoperative bleeding.[4]

Several medications have been reported as influencing bleeding after tonsillectomy and adenoidectomy. The use of aspirin in the postoperative period has rather definitely been shown to increase the chance of bleeding.[7,9,10] Vitamin K and vitamin C given before and after operation were found by some surgeons to have no effect,[9,11] and by others to be beneficial.[12] Koagamin given preoperatively in a "double blind" study did not reduce the amount of primary bleeding.[13] Adrenosem was found by some to have no effect[13] and by others to reduce bleeding.[14,15] Premarin, when given before surgery, was also found by one observer[13] to have no effect on bleeding during operation and by another[15] to be definitely helpful in preventing hemorrhage during and after surgery.

Results

Secondary Bleeding.—There were no cases of secondary bleeding from the tonsil fossae in the present series. This result confirms Emerson's report of 1,000 consecutive tonsillectomies without postoperative hemorrhage.[1-3] There were an undetermined number of cases of very mild secondary adenoid bleeding. Usually the mother would report by telephone that the child would be bleeding slightly or moderately from the nose. In every case, rest and ice packs stopped the bleeding. No records were kept of the number of patients having this experience. Only two patients had secondary adenoid bleeding severe enough to require attention. One boy bled on the second postoperative day and required readmission to the hospital, insertion of a postnasal pack and a transfusion. One girl had to be brought to the office for removal of a clot in the adenoid fossa and administration of coagulant drugs. The incidence of significant secondary hemorrhage is shown in table 1.

Table 1.—Moderate to Severe Secondary Hemorrhage Following Tonsillectomy and Adenoidectomy (534 Cases)

Secondary Hemorrhage	Tonsil Fossae	Adenoid Fossae
	0 (0%)	2 (0.37%)

Table 2.—Primary Hemorrhage Following Tonsillectomy and Adenoidectomy, Not Including Patients Who Had a Postnasal Pack But No Medication (534 Cases)

Primary Hemorrhage	Tonsil Fossae	Adenoid Fossae
Mild	0 (0%)	123 (23%)
Moderate	0 (0%)	5 (0.93%)
Severe	0 (0%)	3 (0.56%)

Table 3.—Prevention and Control of Mild Primary Adenoid Hemorrhage (534 Cases)

Prevented by postnasal pack alone	32	(21%)
Controlled by medication alone	87	(56%)
Requiring pack and medication	36	(23%)
	155	(100%)

Primary Bleeding.—Bleeding occurring from the time the patient leaves the operating room to 24 hours thereafter is considered primary bleeding. As has been stated, if the nasopharynx fills with blood after two or three suctionings following removal of the sponges, this bleeding is considered enough to require a postnasal pack. Oozing from the nostrils while the patient is in the recovery room or in his bed that continues 20 to 30 minutes after the operation is considered bleeding enough to require the injection of one or more doses of coagulant medications (Adrenosem, Koagamin, or Premarin).

Postnasal packs were put in at the close of the operation in 36 boys and 32 girls for a total of 68 or 12.7 per cent.

One or more injections of medication were given to 123 children (23 per cent) after the operation, 67 of whom were boys and 56 girls Of this total number, 36 had also had postnasal packs inserted at the time of operation and 87 had not. One to three doses of the medications alone were successful in arresting the oozing in 79 of the 87 children without packs (90 per cent). Five patients had more persistent bleeding and required four to six injections before oozing stopped. In three children (two boys and one girl) the bleeding was not controlled by medication and a postnasal pack was inserted from two to 10 hours after the operation.

There were no cases of primary bleeding from the tonsil fossae. Table 2 summarizes the incidence of primary bleeding. Table 3 summarizes the prevention and control of mild primary adenoid bleeding.

EVALUATION OF POSTNASAL PACKS.—Postnasal packs were inserted in the operating room in 68 children. In 32 of these children no further bleeding occurred. It was necessary, however, to give one or more doses of medication to the other 36 in this group, an incidence of 53 per cent. This result indicates that our present type of postnasal pack is only half as effective as it possibly could be. Our next project is to design and test new and different types of packs. It has also been stated that less bleeding occurs from the adenoid area if the adenotome is not used at all, but only the curette. We also plan to evaluate this method in a series of patients.

Summary

The operation of tonsillectomy and adenoidectomy was performed on 534 children in a two year period. The technique of surgery is described. Careful suturing of the tonsil fossae has completely eliminated postoperative hemorrhage from these areas.

Bleeding from the adenoid area was, however, rather common. When it was visible at the end of the operative procedure, a postnasal pack was inserted before the patient was removed from the table. These packs were inserted in 68 children, or one out of every eight. The postnasal pack was successful in completely controlling the bleeding in only one half of the patients in whom it was inserted. One half required injections of some medication to aid in blood coagulation. Of the 466 patients who did not have a postnasal pack, 87, or one out of every five, had enough oozing of blood from the adenoid area to require one or more injections of medication. This was effective in 79 of these children. Only 10 patients, or one out of every 53, had a troublesome amount of postoperative adenoid bleeding. Of these, five required several doses of medication and four required postnasal packs inserted some time after the operation. Only one needed a blood transfusion, and one required removal of a blood clot from the nasopharynx.

Our present problems are to find a better way to remove the adenoids and to design a more effective postnasal pack.

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Special Article

Medical Research at the University of Miami

The responsibilities of a medical school, like all Gaul, are traditionally divided into three parts. The classic three are teaching, research and patient care. All three aspects have grown and developed in recent years, and the burdens placed on both medical students and medical faculty have been commensurately greater.

If one had to pick out one aspect which has developed most markedly, it would undoubtedly be medical research. Whatever the criterion—the budget of the National Institutes of Health, the campaigns of voluntary health organizations, the volume of medical papers published, or the number of reports at medical meetings—there can be no question that research is a booming business.

The medical school at the University of Miami, though comparatively young, has participated in that boom. In 1952, when the School of Medicine opened its doors, it had a single research program. Today it has more than 200. In 1952, it had $2,500 in research allocations. Today it has nearly $4,000,000 a year. The fact that it has so large a number of research programs, so well financed, is something of a tribute in itself to the caliber of the research. An account of a small portion of the research follows.

Anatomy

One of the research programs of the Department of Anatomy has sought to localize the cellular source of the hormones of the anterior lobe of the pituitary. A new cell has been described in the dog pituitary which appears to be the source of ACTH. Supporting evidence has been accumulated for the existence of two different types of gonadotrophs as the sources of FSH and LH.

Techniques have been developed to study minute changes in the electrical and mechanical function of the heart in response to various metabolic substances, and to microwave radiation.

The relationship of the thyroid to certain leukemias has been explored, and it has been found that lowering thyroid function prolongs the survival time of tumor-implanted animals.

Studies are in progress on the detection of cytochemical changes to distinguish between normal and malignant cells. An extract is being prepared which, it is hoped, will prevent leukemia in a highly susceptible strain of mice.

Cardiology

An electronic programmer has been devised which, in combination with cardiac catheterization, releases measured amounts of medication at given phases of the heart cycle. Current research is utilizing this programmer, together with angiography, to investigate the in vivo lysis of arterial thrombi.

Experimental work in angiography is also developing refinements in cardiovascular spot-filming techniques, using new biplanar motion picture angiography.

The metabolism of collagen has been under study in this department. The relationships of collagen to the aging process and the physiological, inorganic and physical chemical approaches to the process of calcification are continuing programs. Research has shown that in response to superficial injury, the proliferation of fibroblasts is greater and of longer duration in the male than in the female animal. This work has won two Ciba international prizes.

Current research involves study of the proteolysis of collagen, the physical properties of collagen fibers, the isolation of certain esterified amino acids in the neutral salt-soluble collagen, the hydroxylation of proline in the cell particles. All these studies are pertinent to an understanding of the aging process and the degenerative diseases of old age.

Dermatology

The Department of Dermatology has had 29 scientific papers published during the past 12 months. Its faculty members combine the disciplines of clinical medicine, physiology, bacteriology, histology, electronmicroscopy, pharmacology and biochemistry.

This report was submitted by Mrs. Lillian A. Gluckman, Director, Medical News Bureau, Public Information Office, University of Miami School of Medicine, Coral Gables, and was prepared from summaries of research projects at the University of Miami.

During the past year members of this department have identified erythrasma, heretofore considered a fungus disease, as bacterial in origin. They isolated a bacterial form, infected human volunteers, reproduced the disease with an isolated organism and recultured the organism from the lesions thus produced. They found that antibacterial agents eradicate the organisms from the lesions and produce complete healing.

The University of Miami dermatology department was the first to use the antifungal antibiotic, griseofulvin in man and has continued to investigate the action of this substance. It has determined the method of absorption of griseofulvin and the way in which it operates. Resistance to griseofulvin has been found to result from in vitro resistance of the organism or, in most cases, to inadequate absorption from the gastrointestinal tract, particularly in conjunction with high fat meals.

Recently a very sensitive humidity chamber and an electronic device for measuring sweating and cutaneous water loss have been devised here. These will provide extremely accurate measurement of the amount of water loss under different conditions and knowledge of the structure and function of the outer layer of the human skin as a barrier to water loss. Precise values for water loss, for normal sweating and nonsweating skin have been determined by this method and will shortly be reported.

Clinical studies of topical steroids by the double blind paired comparison technique indicate that triamcinolone acetonide in a concentration only one tenth that presently available commercially is more effective than 1 per cent hydrocortisone in topical therapy. The practical implications of this work are obvious.

The abundant amounts of sunshine available in Florida have been subjected to scientific quantitation. The nature and duration of the effects of both artificial and natural sunlight on human skin have been measured by reflectance spectrophotometry.

Work in progress in this department includes studies of the glucose in human epidermis, physiologic and anatomic correlates in regenerating epidermis, electron microscopic and histologic studies of the embryologic development of human skin and its appendages, organ culture of human skin, bacteriologic and epidemiologic studies of the erythrasma organism, correlation of geographic distribution of rats with the chemistry of fluorescent substances in rat hair, and quantitative analysis of the amino acid composition of protein isolates from human epidermal tissues.

Preventive Medicine

An outstanding public health program was carried out by the University of Miami School of Medicine with the cooperation of the Dade County Department of Public Health and the Dade County Medical Association. Through the use of nearly half a million doses of the Cox trivalent polio vaccine, it has been possible to eliminate polio and the polio virus from Dade County for the last 18 months. There has not been a clinical case of poliomyelitis or a polio virus reported during that period of time.

Further studies are progressing on the consequence of this research with regard to other enteroviruses.

Internal Medicine

The Department of Medicine is a participant in the national cancer chemotherapy service. It has, during the past several years, screened in animals compounds designed to treat several kinds of cancer. It has tested a few of these compounds in man.

Through collaboration with other departments and the University of Miami cancer research laboratory, strains of rats have been inbred for upwards of 75 generations and a standard animal has been developed against which drugs can be tested.

Equipment for biplanar cineangiography has been installed in the teaching hospital of the School of Medicine, and the collaboration of cardiologists, radiologists, ahd biophysicists has developed several new techniques, the use of which is still expanding.

The pygmy marmoset, a new laboratory animal, has been imported, and breeding studies are now being carried on so that this animal can be used in various kinds of research. The colony now numbers approximately 500 animals. The pygmy marmoset, about the size of the laboratory rat, offers to the experimenter the advantages of research in primates without the tremendous difficulties of housing and handling the larger monkeys. The full grown marmoset weighs less than a pound and is conveniently small.

Other research projects cover urinary tract infections in the aged, study of obstructive emphysema, and ventricular fibrillation following acute myocardial infarct.

Neurology

A new method has been devised for measuring cerebral blood flow. Radioactive iodinated antipyrine permits measurement of minute by minute changes in cerebral circulation and metabolism. These studies, done in normal persons, are now being extended to changes which occur in cerebral vascular disease and various organic brain syndromes.

Investigation of normal and abnormal carbohydrate metabolism in the brain of living persons has been carried out by measuring changes in various stages of Krebs' cycle in normal and disease states.

Neurologic and pathologic correlation of respiratory abnormalities in diseases of the central nervous system, the study of changes in the electroencephalogram in aging, the appearance of fluorescein in the retina of persons with normal and abnormal carotid circulation are other studies.

Physiology

A Center for the Study of Cellular Aging was organized at the University of Miami in 1960 under the leadership of the departments of physiology and biochemistry and with the cooperation of several other disciplines. Very wide ranging and basic problems in the aging process in the cell and in the relationships between cell and host are being studied.

Results as yet are in preliminary phases. Diffusion chambers containing cells from old animals in young hosts and from young animals in old hosts are being studied to check processes of erythropoiesis. Efforts are being made to find out whether the erythrocytes of old animals differ from those of young animals and whether erythropoiesis can be stimulated as readily in old as in young animals.

The experimenters in this field are also seeking to establish whether liver regeneration is as rapid in old as in young animals and whether the internal environment plays a part in determining the rate of cell division.

Studies of animals in activity cages and metabolism under stress have been carried on.

One investigation has shown that serotonin decreases the number of the various sizes of microspheres which can pass through the pulmonary circuit of the dog.

Pediatrics

A major research program is pediatric endocrinology. The endocrine laboratory is studying the adrenal response of children to severe and overwhelming infections, particularly meningitis and meningococcemia. Other studies are being conducted with the department of surgery on adrenal response to the stress of total body perfusion.

A method has been established to measure the excretion of one of the steroid hormones (16 androstene) and further research is being carried out to determine its relation to the metabolism of the adrenals and gonads. It is hoped that measurement of this steroid may provide an index to the normal process of pubertal change and perhaps to diseases in which virilization occurs.

A new research program in this department involves a study of hormone metabolism in twins to determine whether genetic patterns exist. Should genetic mechanisms be uncovered, they might throw light on the transmission of congenital errors of metabolism. Other studies of congenital abnormalities are being carried on through chromosomal research in aborted fetuses. The examination of fetal tissues for chromosomal abnormalities has shown that the techniques are feasible, although the data are not significant.

A study of amino acids in 250 mentally retarded children has shown that 8 per cent of these patients have abnormal excretion patterns of amino acid in the urine. These studies will be continued in the future to determine whether disorders of metabolism are related to retarded mental development.

The Department of Pediatrics has been participating in nationwide programs for the management of malignant disease in children. Fifty patients have been treated with a new compound, vincaleukoblastin, for the treatment of leukemia, and surveys have been begun on patients with solid tumors. Lymphangiograms are being used to demonstrate lymph node abnormalities in malignant conditions, and to determine the response of these nodes to therapy. Several diseases of the newborn are under study, including the use of digoxin for respiratory distress syndrome, the study of fibrinogen determination levels, platelet levels, and the use of heparin.

A new clinic has been established with grant funds for clinical observation of patients with cystic fibrosis of the pancreas. Some 50 patients are now being cared for and studied. The effect of Aldactone is being considered. There is also a study of the parents of these children for possible observation of a genetic factor. Other programs

include a study of albedocone, a study of gamma globulin, and a screening test for detection of cystic fibrosis in the population. A sample community of 2,400 people representing a general segment of the population will use a hand print test for the presence of excess chloride in sweat. An attempt will be made to determine whether this type of screening can pick up asymptomatic patients with cystic fibrosis in the population.

A bacterial laboratory is being set up for the study of newly introduced antibiotic agents, childhood tuberculosis and bacterial infections in cystic fibrosis.

A five year study on the evaluation of different methods of treatment in the management of the patient who has ingested strong alkalis has shown that early esophagoscopy is essential and that steroids (prednisone) are of benefit in the prevention of stricture.

Surgery

Radio-opaque clots which produce severe and almost uniformly fatal hemorrhagic pancreatitis in animals have been treated with fibrinolysin, resulting in recovery. Serial x-rays showed dissolution of the radio-opaque clot.

Regional perfusion has been developed as a technique for the administration of cancer chemotherapeutic agents. An abdominal tourniquet devised here has been used to keep perfusing agents out of the general circulation. The technique of regional perfusion has been extended to bone and joint infections and malignant disease of the kidney and pelvic areas.

Heart-lung bypass techniques have been used in extensive open heart surgery. Currently, investigation is proceeding on shock phenomena in association with the bypass technique. Attempts are being made to delineate the mechanism and location of the sequestration of large volumes of circulating blood in the lungs and other tissues occurring in present heart-lung operations.

An investigation is proceeding in animals on the use of plastic polymers (bone glue) in the fixation of mandibular fractures without wire fixation.

In another program a skin adhesive is being tested in rabbits to determine whether skin lacerations may be repaired without the use of sutures.

Studies in peptic ulcer involve the stripping of the gastric mucosa and submucosa, removing approximately 70 per cent of the acid-secreting cells. Submucosal mobilization of the antrum and remaining acid-secreting mucosa permits relining the stomach. The animals are then tested for the amount of decreased acid activity and the protection afforded by this procedure against histamine-provoked ulcers.

The department is also studying deep hypothermia by arteriovenous cooling.

Biochemistry

A major project in the Department of Biochemistry has been a study of the interaction of phospholipids in the formation of thromboplastin. Studies through chromatography and other techniques have used the lipids from soy beans to influence the thromoboplastin content of the blood.

The biochemical endocrine laboratories have done extensive research in the sex hormones, using radioactive isotopes to study the synthesis of hormones in gonadal tissues. They reported during the past year a major breakthrough in the field of hormone metabolism when they told of the successful synthesis of progesterone from gonadal tissues in vitro. By stimulating the tissues with anterior pituitary-like hormone, they successfully induced the corpus luteum in vitro to manufacture its characteristic hormone.

The Department of Biochemistry is associated with many medical school programs in other departments. The endocrine laboratory is working with the Department of Pediatrics on the problem of steroid chemistry in children and young adults. It is cooperating with the Department of Medicine in biochemical studies of fibrinolysin, and it is cooperating with the Department of Surgery in studies of hormonal regulation of neoplastic growth.

There is also work in physiology, psychiatry and microbiology.

Microbiology

Normal human serum has been found to be bactericidal for a wide range of gram-positive and gram-negative bacteria. The reaction is due to one or more protein components of serum, and the Department of Microbiology has been seeking to isolate specific protein fractions responsible. Results to date indicate that the bactericidal activity resides in a single chromatographic separation entity.

Research on the viruses of marine fish has produced two interesting discoveries: (1) A ciliated protozoan was isolated from tumors of sea horses, which may be a vector for virus infections in marine life. (2) Cells from marine fish grown

in tissue culture were found to produce a substance inhibitory to certain mammalian viruses.

Pooled human gamma globulin has been found highly effective in protecting mice from strains of Pseudomonas. Gamma globulin is already used to provide passive protection in humans against infection following exposure to polio and other virus diseases. Current research indicates that it may be useful in the prophylaxis of Pseudomonas infections. The mechanism involved is now being studied.

The department has on-going studies in virology, genetics, parasitology and immunology.

Obstetrics and Gynecology

The Department of Obstetrics and Gynecology has conducted careful screening tests for cervical cancer over a period of years. A positive cytology registry is maintained in Jackson Memorial Hospital. Every female patient who appears at the hospital for whatever cause is given a vaginal smear test. In case of suspicious cytologic findings the patient is recalled for repeat study and treatment. The use of the registry is providing invaluable statistical material on cytologic changes in a single individual. The routine testing has made tremendous inroads in the former death rate of cervical cancer.

Several new compounds are being tested in this department, among them one for the prevention of premature labor and another as a nutritive supplement in pregnancy.

The department also pioneered in conducting a special symposium on medical aspects of marriage and family problems. The concern of the physician in the health of the patient, old and young, in his family setting was underlined.

Pharmacology

The Pharmacology laboratory has completed within the past year studies in the hazards of microwave (radar) radiation. They have proved that the harmful effects of microwave radiation are due to heat, and that these effects can be greatly diminished by (1) intermittent exposure and (2) air motion.

The Department of Pharmacology has also contributed to the understanding of the nature of substances which produce the lacrimating and respiratory effects of air pollution. It has synthesized several nitro-olefins and identified them as lacrimating substances in polluted atmosphere. A new research program inaugurated recently in this department will seek to establish a simple chemical test for monitoring the concentration of lacrimators in the air. This would, hopefully, make the test independent of the subjective responses of human subjects.

The department is also conducting several toxicity studies on motor oils, cutting oil waxes, and the role of aromatic amines in cancer of the bladder. The preliminary work on this form of cancer done by the Department of Pharmacology has implicated as factors some industrial chemicals. Several industrial concerns which used these substances have quietly changed the products they are using so that their employees no longer run this risk.

President's Page

Has The Golden Age of Medicine Passed?

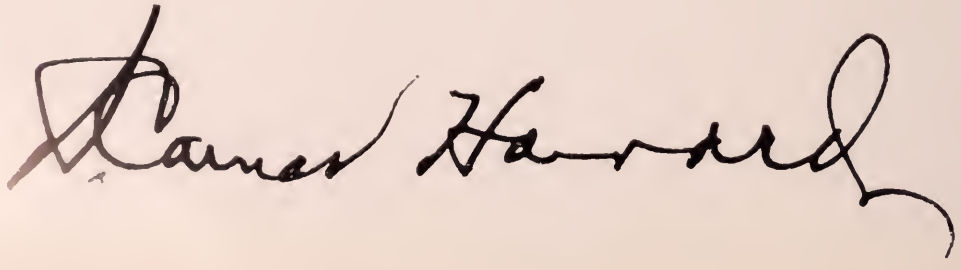
During the last year I have heard this question answered affirmatively many times. I cannot agree entirely.

Medicine as a science has probably advanced more in the last decade than at any time in the history of medicine. This progress has not been limited to any one field of medicine. The diagnosis and treatment of diseases have surpassed our most optimistic hopes. We cannot, therefore, say that as far as medicine per se is concerned, it has fallen back. Every day we are approaching the solution to such problems as cancer and other supposedly incurable diseases. During our lifetime we have seen several diseases brought under control that formerly could not be touched.

Those who state that the Golden Age of medicine is past are thinking about it from the doctor's standpoint and not from medicine alone. With them I will have to agree more or less; however, I believe that this situation we can control to some extent. If medicine were left alone to solve its own problems, there would be no troubles. Today we have a number of groups, including the government, trying to tell us how, when, where and everything else about the practice of medicine.

Unless we as a group work together, solve our problems and see that the solutions are carried out, the Golden Age of medicine will have certainly been lost and, in my opinion, forever. It is much later than we think, and unless we as individuals and groups work toward the preservation of medicine, we cannot expect any help from outside. I do believe that through the efforts of such men as our own Dr. Ed Annis and others all over the country, we are slowly gaining in our fight for freedom not only in medicine but in all of our everyday activities. Each one of us must bear in mind that this is something we must do and that we cannot "pass the buck" to somebody else.

In my opinion medicine will continue to advance regardless of what controls might be put upon it, but certainly advancement cannot be as rapid under certain bureaucratic rules and regulations as it has been in the past when medicine was run by medicine alone. Doctors know what is needed in medicine. They have proved in the past that they can supply this demand, and I think that they should be allowed to do so. The time has long passed when doctors can excuse themselves from taking an active part in the political affairs of our nation. There is no doubt that the doctor alone with his friends controls a large segment of votes. It is his duty to see that these votes are for the right cause. I certainly hope that medicine will always, as it has in the past, be for the alleviation of the sick and that these votes will never be used for personal gain in any way. Remember we are doctors as well as citizens. We must not abuse the prerogatives of either.





Editorials

Problems of Tonsil and Adenoid Surgery

Hemorrhage following tonsil and adenoid surgery is certainly the most troublesome complication in that procedure and consequently many papers have been written on the subject, one of which is in the present issue of The Journal. The author's statistics on postoperative tonsillar bleeding certainly cannot be bettered, but I would be interested to know about the immediate morbidity as well as the long term result with this particular technique. It has been my impression that when I sutured only one fossa, not by the technique presented here, the patient usually would complain more about that side. I wonder whether the obliteration of the fossae results in adhesions between the pillars or permanently damages the pharyngeal musculature. I have certainly seen many adult patients with chronic complaints when there was much scarring in the fossa.

In trying to analyze my surgical complications through the years, I have come to believe that most, if not all, are produced by an error in technique at the operating table, and tonsils and adenoids are no exception. We will never eliminate all of our faults, but constant self criticism and a continuing effort to improve our surgical technique will go a long way towards eliminating complications. I am sure that I had fewer tonsil and adenoid hemorrhages in my later years than in my earlier ones, and I attribute this result to improvement in over-all technique.

In general, I believe that the major causes for postoperative tonsillar bleeding are stripped up or torn muscle fibers and pieces of tonsil left behind. In a recent article[1] in the Southern Medical Journal, an increased incidence of bleeding was noted in cases of old quinsy, in older patients, where usually there has been repeated infection, in males, and in cardiac disease. Certainly in the first two, a clean tonsil dissection without disturbing the muscle fibers is most difficult. In contrast, the child whose tonsils practically fall out with very easy dissection usually has minimal bleeding; and incidentally, this patient probably is not to expect much benefit from the procedure unless the indications were primarily for adenoidectomy. Thus, tonsillar bleeding may be directly related to the need for surgery and the difficulty encountered, and the quality of the surgery.

I agree that in children adenoid bleeding is much more common than tonsil bleeding and also that if a "better way to remove the adenoids" could be devised, this would be commendable. In the absence of an improved method, I believe that many bleeding points in the nasopharynx can be found and clamped and this procedure combined with pressure will control the great majority of instances of adenoid bleeding provided enough time is allowed and provided a clean adenoidectomy has been performed. In the paper presented, in 12.7 per cent of all cases postnasal packs were left in, and over one half of these were admittedly ineffective. Probably 95 per cent were ineffective, and certainly 100 per cent of the patients were made uncomfortable by the packing. I do not think that a "more effective pack" is the answer to adenoid bleeding.

As for the use of coagulant drugs, I have thought that perhaps Premarin is helpful. All of the others are probably useless and when employed only serve to provide us with a tool to take credit for nature's work.

My plea is that the physician performing tonsil and adenoid surgery, whether general practitioner or ear, nose and throat specialist, constantly try to improve his surgical technique never assuming he has mastered it, keep the patient in the operating room until good hemostasis is effected, and not evaluate his ability by the speed with which he can turn out patients.

1. Proctor, D. F.: Bleeding Following Operations Upon the Tonsils and Adenoids, South. M. J. 54:1358-1362 (Dec.) 1961.

William H. Anderson Jr., M.D.
Ocala

Volume XLVIII
Number 10

The Trojan Horse

The insidious encroachment of government upon the private practice of medicine is viewed with alarm by the medical profession. The steady advance of this Trojan horse is viewed with similar apprehension by the voluntary health insurance companies of the United States. Other than stand by and lose by default, is there anything these mutually interested groups can do about the problem? I believe the answer is yes. To promote the objective of keeping the government out of the private practice of medicine, the medical profession and the voluntary health insurance companies, through the auspices of the medical relations committees of the Health Insurance Council, have earnestly begun to work together towards a better understanding of each other's problems. One way of doing so is to publish an occasional explanatory article about some particular phase of mutual interest. A good example for a starter is major medical or comprehensive health insurance. This is the newest, the broadest and the best coverage available. Life insurance protects the family when natural death occurs. Major medical insurance protects the wage earner and his family against financial death caused by serious or protracted illness or injury. More than 30 million American wage earners have this type of coverage today.

In major medical insurance no attempt has been made to set any schedule of fees for physicians and surgeons. Companies are obligated by contract to pay fair and reasonable charges on the claims which come to them. They have no desire, duty or responsibility to set the fees of a physician or surgeon under major medical contracts in their claim departments or home office medical departments if they are used rationally.

In following up occasional questionable fee claims under major medical contracts, there has been a need for an appeal mechanism within county medical societies. This need is now being filled by the establishment of insurance review or mediation committees. The impetus for the establishment of such committees has come and should come from within the profession. Such committees have been set up in the past year in single or multiple county societies and in many states.

In evaluating a claim and in deciding whether or not it should be referred to a review committee, what are the factors taken into consideration in studying the charges made by physicians and surgeons, where the charges seem excessive? It has been found that careful screening of cases is the most important element in appeals to the review mechanism.

1. The case is studied to determine whether all the pertinent information on the medical or surgical care is present. If the information is incomplete, a copy or abstract of the operating room record or other records is requested. Surgeons, particularly, sometimes give very sketchy information in their reports to claim departments. The physician may be written to directly regarding the items of care. Inquiry is made into the matter of complications or special difficulties encountered which will often have a bearing on the fee charge.

2. A study is made of the background of the physician involved as regards his training, specialty, board certification, hospital connections and staff positions in the hospital or the medical school.

3. Also studied is the physician's location, locally and geographically, since there are different levels of charges in different cities and geographical areas.

4. Often the patient is in a certain general income bracket, and physicians usually respect the factor of low income of their patients, in setting a fee.

5. A record is kept of only those few physicians who have in the past charged what seemed to be higher than reasonable fees.

6. While they are not employed as a guide or a rule for action, one can take a look at such established fees for services as are listed under Blue Shield contracts, Medicare schedules, and schedules of fees such as the California and other relative value schedules. These are taken as sources of information which were developed by physicians. Certainly there is some relationship between these fee schedules and what is a reasonable fee for a given medical or surgical service. Such schedules are not used as a rule of action.

7. For hospitalized cases study the type of accommodations which the patient had during his or her hospital stay. Was this a ward, semiprivate or private room case? Were private nurses necessary? This practice is in recognition of the long-established relationship between the accommodations used or chosen and the fees for medical and surgical care or treatment.

Who are the men in the home offices who look at the surgical and other types of major medical claims which come from physicians in each day's mail. In some of the larger home offices in the industry, these claims may run from 500 to 800 claims each working day. It would be understandable that a home office physician cannot review each and all of these claims, nor is it necessary that he do so.

Claim departments are headed by executives who have devoted a lifetime to the study and handling of claims and dealing with physicians and hospitals. Their relations have been of the best. Under these executives there is a staff of able young men who for the most part are college-trained and who are progressing in their chosen field with the company. They develop an excellent working knowledge of medical and surgical procedures. They are real students. Again, they are well versed in the technicalities of health insurance coverages and contracts. Any physician in clinical practice would be amazed at the working knowledge these men develop concerning medical and surgical matters.

The bulk of surgical claims are those involving the more numerous and technically simpler operations and procedures such as tonsillectomies, appendectomies, uncomplicated cholecystectomies and simple fractures. In these cases charges, even though they may vary some with the income bracket of the patient, are generally within reasonable limits. The fact is, and this is very important, that better than 90 per cent of surgical claims are approved without question within a matter of hours or a working day.

In the remaining 10 per cent of more difficult claims or a questionable claim, there is a line of reference from claim reviewers to claim consultants. Where the surgery performed is highly technical in description and when complications are reported or overcharges are suspected, the claims are regularly sent to the medical department for professional review and opinions. From one to four physicians may see a given questionable high fee claim. One of the reasons for the existence of a medical department in a home office is that the interests and activities of practicing physicians may have representation.

In the review of a day's major medical insurance claims there will be some claims in which the fee charged by the physician or surgeon seems definitely outside the limit of what would appear to be reasonable on the basis of all the facts presented, and out of line with extensive claim experience, in a given surgical operation or medical procedure.

Having questioned the medical or surgical charge in a given case, a company may use one of three approaches:

1. Discuss the matter with the physician or surgeon by telephone.
2. If the physician is at a distance, write a letter.
3. Send a field claim representative to interview the physician.

In these contacts an endeavor is made to give the physician or surgeon something of the philosophy of major medical insurance, to point out a few of the principles under which health insurance must operate if it is to succeed under private enterprise. The case is reviewed with the physician or surgeon to be certain that the company has the facts which have a bearing on the fee charge. Finally, the possibility of an adjustment in the fee charge is discussed. This discussion leads in many instances to a willingness on the part of the physician or surgeon to bring his charge more nearly in line with the charges of other physicians and surgeons of comparable skill in his practice location.

It is only after sincere efforts to adjust a claim with the physician or surgeon that an appeal may be made to an established review or insurance mediation committee of a county or state medical society for an opinion and guidance as regards a fair and reasonable fee.

Some physicians and surgeons will insist that any charge made is their usual or customary fee; some few will refuse to discuss the matter of the fee with anyone. Then there are a few instances of complex, complicated or unusual operations in which the charges are high and in which it is difficult to form a sound opinion alone, in the home office. Such are the cases where it is desirable to use an insurance review committee in a county medical society.

Today there is a realization within the profession that excessive or unwarranted charges for medical or surgical care can reflect badly upon the good name of the medical profession. Here and there individual complaints of insured and uninsured patients get into the papers or individual experiences are cited in magazine articles. The tens of thousands of people who are happy with their doctors and their health insurance coverages rarely get the headlines.

Private enterprise must be our continuing goal. We must do everything within our power to make

work. It has to work for there, already inside the gates, smiling benignly down upon us all stands the Trojan horse.

RICHARD A. NELSON, M.D.
JACKSONVILLE

Herpetic Keratitis

Dr. Herbert E. Kaufman and associates have recently reported the treatment of herpetic keratitis with a new drug termed IDU. This treatment has been effective in herpes simplex of the cornea and in dendritic keratitis. The experimental work shows it to be very effective in the early and advanced cases. The instillation of the solution IDU has to be carried out as often as every two hours. IDU solution is 5-iodo-2′-deoxyuridine. The solution to date has been somewhat unstable and has to be prepared every two to three days. For this reason it has not been been released for general use. At the present time Dr. Kaufman and associates are still in the process of evaluating the new drug and developing a stable solution. The drug prevents multiplication of the virus; it is administered as an eye drop and does not require cautery. The experimental work has been done in a controlled series of rabbits and human beings. IDU is nontoxic and acts by interference with the viral-directed synthesis of desoxyribose nucleic acid. It has been found to be partially effective against experimental virus infections in tissue cultures and against anomalous DNA synthesis in cancer.

Dr. Kaufman, who reported the research work on IDU, has recently been made the head of the Division of Ophthalmology of the University of Florida College of Medicine. He is particularly anxious to carry on further research in humans with this solution. Patients who present themselves to the Eye Clinic will be seen and provided with medicine without charge either for physician's services or for the drug and will be followed during treatment by both the University of Florida Eye Service and by the referring physician.

Herpetic keratitis has been difficult to control and many times causes great loss of vision. For this reason ophthalmologists are hopeful that IDU will be the answer to our problem for these cases.

SHALER RICHARDSON, M.D.
JACKSONVILLE

Committee of Seventeen

This is the first of the efforts of the Association's Blue Shield Advisory Committee to use The Journal of the Florida Medical Association as an instrument of opinion dissemination. As most of the Association members know, until recently the Committee of Seventeen published and mailed a monthly editorial to the entire membership. The articles were reprinted from the

Medical Research in Southern Universities

In this issue of The Journal of the Florida Medical Association there appears a summary report of the research completed and in progress at the University of Miami School of Medicine. Such a report cannot present the entire picture of the University's investigative work, but it does bring into focus the massive amount of energy which is expended by staff members in an effort to improve the practicing physician's ability to help his patient.

The Journal plans to present similar reports from other Southern medical schools through the year, in the belief that through this medium the Florida Medical Association membership can be better informed of research in progress and newer clinical developments; at the same time, each university has the opportunity to present its investigative work. The series is offered in the hope of fostering a greater mutual understanding between the clinician and the university.

These summaries are not intended as a basis for the treatment of patients, but to serve as a reference for seeking more detailed information on any point of especial interest. It is hoped that interest will be aroused and specific questions will be asked for then The Journal will have achieved a major reason for being.

T.M.

Pinellas County Medical Society's bulletin, "The Mail Bag." Dr. W. C. McConnell and the Pinellas County Medical Society have our sincere thanks for the years of making possible that well accepted method of keeping you informed.

Since the first meeting of the Committee in 1956, we have performed many functions in relation to the Association's responsibilities to you and Blue Shield. These include surveys, fee scheduling, meetings with you, and volumes of advice and counsel to the Blue Shield Board of Directors, but basic to all of our deliberations and actions has been the knowledge that we must keep you informed. We have bent every effort in that direction and shall continue to do so.

Largely through physician understanding, resulting in greater unity of purpose, we have seen our Blue Shield meet changing public demands with a Federal Employees Program and other improvements in scope and quality of medical care coverage. At this writing, serious humanitarian and political consideration is being given to a nationwide Blue Shield program for the aged. The full support of the American Medical Association is behind the development of this voluntary solution to political compulsion. We in Florida have but to agree on the extent of our dollar sacrifice, by accepting reduced fees for those of small means, and to cooperate with all other Blue Shield Plans in providing a uniform scope of coverage, in order to make it a practicable program for the aged.

The success of this program will depend more on our willingness to make it work than on any other single factor. Physicians have had greater challenges, both medically and economically, and have faced them with the strength of positive united effort. I am sure we can do equally as well with this one.

Ralph M. Overstreet Jr., M.D.
West Palm Beach



Clinical Comment

Florida Pediatric Society Meeting

The thirty-fifth meeting of the Florida Pediatric Society was held November 9-12, 1961 at the Cherry Plaza Hotel, Orlando. The theme of the program was problems of adolescents and the various factors peculiar to them. Guest speakers included Dr. J. Roswell Gallagher, Director of the Adolescent Unit of the Boston Children's Hospital, Dr. Paul L. Adams, Child Psychiatrist at the University of Florida College of Medicine, and Dr. William W. Cleveland, Director of the Pediatric Endocrinology Department of the University of Miami School of Medicine. There was an excellent turnout for the scientific sessions, a total of approximately 100 physicians registering. These included some physicians from neighboring states.

Dr. Gallagher opened the scientific session by discussing the physiological and psychological characteristics of adolescents, pointing out their tendency to exaggerate, impatience, ease and speed of forming and giving up close relationships with adults, and high degree of concern for their bodies and themselves. He also discussed some of their physiological characteristics such as the increased iron needs for girls at the menarche, the increased function of the sweat glands, the appearance of functional heart murmurs, gynecomastia, acne, and increased resistance to some infections but a decreased resistance to tuberculosis. During the course of this discussion he pointed out what adolescents are like, what to take into account when treating them, and the various ways that they differ.

Dr. Gallagher then spoke on the office visit of an adolescent to his physician. He pointed out the importance of the setting in establishing confidence and rapport, the technique of history taking and how to get a suspicious adolescent to open up and discuss his problems. He discussed techniques of physical examination and particularly evaluation in terms of the developmental age rather than the chronological age. He emphasized that if the doctor really does not like adolescents, he may be uncomfortable with them. The importance of

seeing them alone was discussed, and it was pointed out that they should understand that he is their doctor and not the parent's doctor, that the problem is the adolescent's, not the parent's. He also pointed out that the parents should be seen first to set the stage, preferably the day before the patient is seen. The physician should confront the child with the problem as presented by the parent, and it should be understood that under ordinary circumstances his doctor will talk to the parent only with his knowledge and consent.

Dr. Adams spoke on "Checklist for Adolescents," discussing how the pediatrician can rate and appraise a teenager's handling of his emotional development. He pointed out that sex is usually not a predominant problem of adolescents, and while they do have sexual urges, these tend to be overrated as a cause of problems. The teenage boy is striving for heterosexual orientation, and should have friendly associations with girls. He should be comfortable around girls and he should be overcoming some of his shyness. He is also looking for vocational orientation. He is becoming aware that money does not grow on trees, and some of his thoughts and inclinations should be directed toward his career. He is beginning to obtain some emancipation from his parents. He is beginning to differ from his parents in many ways and beginning to establish his own freedom in many ways. Dr. Adams also pointed out that the adolescent needs ego identity. He is looking for strength in his own ego, his own ability to make decisions, take responsibility, persist when frustrated.

Dr. Cleveland discussed some of the growth problems in adolescents, dealing with the diagnosis and management of children who display abnormal growth, particularly the short boy with delayed sexual development. He presented several cases of growth problems, discussing the differential diagnosis between hypothyroidism, hypopituitarism, and constitutional delay in adolescent development. He pointed out that in some cases of delayed growth in boys, if there are evidences of a definite psychiatric problem developing because of this, the use of gonadotrophic hormone to stimulate growth and development is indicated. He also presented cases and discussed the problem of Turner's syndrome (gonadal aplasia). In addition, he mentioned that it is doubtful that attempts to arrest growth of girls who are unusually tall by using estrogenic substances should be made because of menstrual difficulties that may occur with the large doses required. After each of these presentations a period of discussion followed with questions and case examples.

Dr. Adams opened the next day's session with a discussion of how to deal with physical defects in an adolescent, especially how such a problem should be seen in terms of values and attitudes about the teenager's body and about himself; and how shame, inadequacy, and uncertainty operate in the physically defective adolescent. He pointed out that a teenager can become a physical cripple without becoming a psychological cripple. He also pointed out that worry over adolescent acne can make a teenager become disturbed emotionally, that the severity of the physical illness is not necessarily related to the psychic effect. He pointed out that family and friends of a physical cripple can tend to be overprotective, or on the other hand, be rejective. Any of these reactions can contribute substantially to the teenager's ability or inability to cope with physical defects.

Dr. Cleveland discussed the differential diagnosis of goiter in children and adolescents, and the mechanism and management of these cases. In discussing the various thyroid substances that might be utilized he stated that desiccated thyroid is definitely the drug of choice because it is safer and has less effect on the protein-bound iodine, which can be utilized as a means of evaluating treatment. He presented several cases of abnormal thyroid function and abnormal enlargement and also discussed the differential diagnosis of thyroiditis, hypothyroidism, and Hashimoto's disease.

Dr. Adams pointed out some important factors regarding the psychiatric referral of adolescents. An adolescent should not be referred to a psychiatrist as a means of rejecting him. Some of the "do-nots" that he mentioned are: do not use the psychiatrist as a wastebasket, do not refer a patient to a psychiatrist with the implication that there is really nothing wrong, do not overrate or oversell psychiatry, do not portray the psychiatrist as a mind reader. The attending physician should refer the teenager to a psychiatrist because he believes that the patient needs a psychiatric work-up in order that someone may understand his problem. The child's own physician should be able to handle many of his problems so that a psychiatric referral should be somewhat of a last resort. It is also important for the physician treating an adolescent to know himself well enough to understand that he may be able to handle some problems and not be able to handle others. A physician should not force himself to work with any given patient. He also pointed out that many

physicians have an unwholesome attitude toward psychiatry, feeling that psychiatry is a nonmedical field. Finally, the physician should know his psychiatrist. He should know that the psychiatrist is willing and able to treat problems of adolescents.

The last portion of the scientific program was a discussion by Dr. Gallagher of cardiovascular disorders in adolescents. The importance of recognizing changes that occur in cardiac status during adolescence was stressed. For example, the murmur of an interventricular septal defect may sound louder with the growth of the heart and increased cardiac output associated with adolescence, and yet not necessarily mean that the opening is any larger. He also pointed out the importance of a careful evaluation of cardiac reserve before allowing strenuous activity, especially after an illness. The ordinary 50 or 100 hops is insufficient. He recommended a four minute up and down step test with pulse rate determinations for three minutes afterwards. He cited examples and comparisons of how this test could reveal poor cardiac reserve when the ordinary test failed to reveal it.

A discussion of obesity in adolescents was participated in by all three speakers. A typical case was presented by Dr. Gallagher in which he pointed out the fact that the treatment of the child as a whole will accomplish far more toward correcting obesity than diets or appetite reduction medication.

A highlight of the meeting was a banquet Friday night held at the Cherry Plaza Hotel. During this banquet Dr. Ludo von Meysenbug was presented a silver tray by the Pediatric Society in recognition of his many years of service. Several of the members spoke of Dr. von Meysenbug and his long, outstanding pediatric career.

All in all, those attending the meeting were enthusiastic about the quality of the discussions, and the meeting was an outstanding success in every way.

John H. Cordes Jr., M.D.
St. Petersburg

Association News



Summary of Board of Governors Meeting Held January 13, 1962

FMA Budget for 1962.—Approved the financial statement for 1961 and adopted the budget for the Association for 1962 of $236,000, including $12,000 for reserve based upon anticipated income of $238,000.

Dues Increase.—Approved for presentation to the House of Delegates a resolution recommending a $10 increase in Florida Medical Association annual dues effective January 1, 1963. Reasons are (1) Increased cost of general and committee activity; (2) Necessity to enlarge building; (3) Increased cost of doing business with no increase in dues in 12 years.

Amendments to By-Laws.—Approved for presentation to House, By-Law changes: (1) To provide for Honorary Membership in Association; (2) Clarifying section dealing with Rights and Privileges ("Membership in the Association confers no vested right to the holder thereof but is a conditional privilege revocable for cause. Each doctor of medicine, by accepting membership in the Association, becomes subject to all provisions of these By-Laws and subject to disciplinary proceedings authorized hereunder.") Recommended that each county medical society review its by-laws and make appropriate changes regarding rights and privileges of members as indicated.

FMCBG and AMPAC.—Approved Florida Medical Committee for Better Government and American Medical Political Action Committee; encouraged all physicians in Florida to join both political action groups—observed that (1) Both groups are separate and distinct from Florida Medical Association as required by law; (2) Effective political action must be carried out on a local level.

Quackery.—Authorized an ad hoc Committee on Quackery.

Journal Editors. — Appointed Thad Moseley, M.D. Editor of The Journal and commended him for outstanding work as Editor Pro Tem. Appointed Franz H. Stewart, M.D. and Charles K. Donegan, M.D. Assistant Editors.

Judicial Council.—Approved report of the Judicial Council: (1) Requesting a county medical society to expel certain members for cause and referred the report to the State Board of Medical Examiners for action. (2) Recommendations concerning the practice of Radiology and referred back to Judicial Council for implementation.

AMA Meeting.—Received information that the 1964 AMA Clinical Meeting will be held in Miami Beach.

Fee Schedule.—Approved report of Committee on Fee Schedules and commended its members for their efforts and good work.

Speakers Announced for Eighty-Eighth Annual Meeting May 10-13, Bal Harbour, Miami Beach



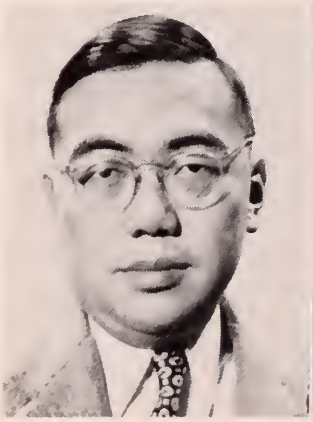
Durward G. Hall, M.D., of Washington, D. C., a member of the House of Representatives, Congress of the United States, from the state of Missouri. Guest of Dr. S. Carnes Harvard, President. Title of address: "How a Physician Member Views Congress." Presentation: Friday, May 11, 11:30 a.m.

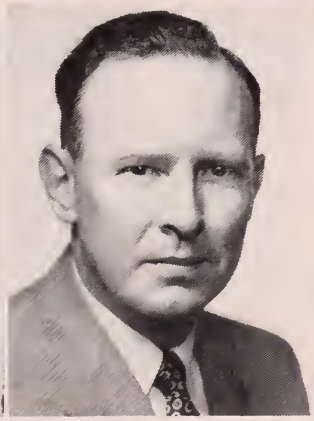




James A. Reyniers, Ph.D., of Tampa, Director of the Germfree Life Research Center. Guest of Florida Society of Pathologists. Title of address: "Germ Free Life and Its Implications." Presentation: Friday, May 11, 2:00 p.m. (left)

Dr. B. H. Landing of Los Angeles, Chief Pathologist, Children's Hospital of Los Angeles. Guest of Florida Academy of General Practice. Title of address: "Cellular Histochemistry." Presentation: Friday, May 11, 2:20 p.m.

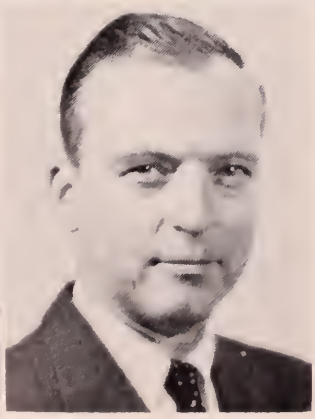




Dr. David Yi-Yung Hsia of Chicago, Professor of Pediatrics, Northwestern University Medical School. Guest of Florida Pediatric Society. Title of Address: "Inborn Errors of Metabolism and Related Genetics." Presentation: Friday, May 11, 2:40 p.m. (left)

Dr. Samuel P. Martin of Gainesville, Chairman, Department of Medicine, University of Florida College of Medicine. Moderator of panel: "Clinical Application of the Basic Sciences." Presentation: Friday, May 11, 3:30 p.m.





Dr. Orvar Swenson of Chicago, Surgeon-in-Chief, Children's Memorial Hospital. Guest of Florida Chapter, American College of Surgeons. Title of address: "Some Problems in Management of Anomalies of the Tracheobronchial Tree." Presentation: Friday, May 11, 4:30 p.m. (left)

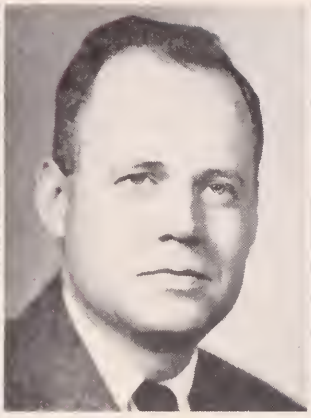
Dr. Ted F. Leigh of Atlanta, Professor of Radiology, Emory University School of Medicine. Guest of Florida Radiological Society. Title of address: "X-ray Diagnosis of Cancer of the Colon." Presentation: Friday, May 11, 4:50 p.m.



Dr. F. J. L. Blasingame of Chicago, Executive Vice President of the American Medical Association. Title of address: "A.M.A.—Happenings and Outlook." Presentation: Thursday, May 10. First Session, House of Delegates. (left)

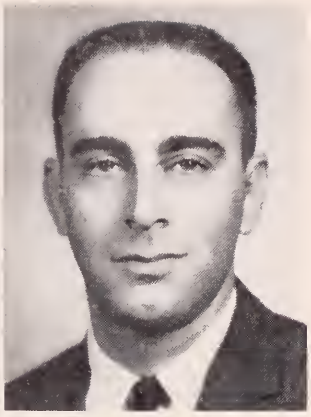
Dr. Warren W. Quillian of Coral Gables. Title of address: "Cat Scratch Disease." Presentation: Thursday, May 10, 3:00 p.m.





Dr. Richard G. Connar of Tampa. Title of address: "Aneurysm of the Abdominal Aorta." Presentation: Thursday, May 10, 3:20 p.m. (left)

Dr. Ralph J. Slonim Jr. of Miami. Title of address: "Selection of the Patient for Cardiac Surgery." Presentation: Thursday, May 10, 3:40 p.m.





Dr. Richard E. Strain of Coral Gables. Title of address: "Cervical Discography and Electromyography in the Diagnosis of Lacerated or Torn Discs." Presentation: Thursday, May 10, 4:00 p.m. (left)

Dr. Arthur K. David Jr. of Jacksonville. Title of address: "Renal Physiology." Presentation: Thursday, May 10, 4:20 p.m.



Schedule of Activities for the Annual Meeting

	Wednesday, May 9	
2:00 p.m.	Pre-convention Board of Governor's Meeting	Pan-American Room*
	Registration Desk Open	Foyer, Grand Ballroom
4:00 p.m.	Blue Shield Board of Directors Meeting	Yucatan-Aztec Room
	Thursday, May 10	
All Day	Registration and Exhibits	Theatre Auditorium
	Woman's Auxiliary Hospitality Room	Rooms 202-203
8:00 a.m.	Registration of Delegates	Medallion Room
9:30 a.m.	First Session, House of Delegates	Grand Ballroom
11:30 a.m.	Annual Meeting, Blue Shield	Grand Ballroom
1:00 p.m.	Woman's Auxiliary — Registration and Board Meeting	Caribbean Suite
2:00 p.m.	First Scientific Assembly	Grand Ballroom
	State Board of Health	Yucatan-Aztec Room
7:00 p.m.	Florida Medical Committee for Better Government	Pan-American Room
	Friday, May 11	
All Day	Registration and Exhibits	Theatre Auditorium
	Woman's Auxiliary Hospitality Room	Rooms 202-203
8:00 a.m.	Board of Past Presidents Breakfast	Gaucho Room
	Woman's Auxiliary Registration	Caribbean Suite
9:00 a.m.	Second Scientific Assembly	Grand Ballroom
	Reference Committee No. 1	Eastward Room
	Woman's Auxiliary House of Delegates	Caribbean Suite
9:30 a.m.	Reference Committee No. 2	Westward Room
10:00 a.m.	Reference Committee No. 3	Pan-American Room
10:30 a.m.	Reference Committee No. 4	Floridian Room

* All meetings are in the Americana Hotel, except those indicated.

11:30 a.m.	General Session		Grand Ballroom
12:30 p.m.	Woman's Auxiliary Annual Luncheon		Medallion Room
2:00 p.m.	Third Scientific Assembly		Grand Ballroom
6:30 p.m.	President's Reception		Starlite Patio
		(Alternate)	Floridian Room
7:30 p.m.	Alumni and Fraternity Groups		
	Duke		Eastward Room
	Emory		Yucatan-Aztec Room
	Georgia		Westward Room
	Hellenic		Pan-American Room
	Jefferson		Caribbean Suite
	Miami		Medallion Room
	Tulane		Carioca Terrace

Saturday, May 12

All Day	Registration and Exhibits	Theatre Auditorium
8:00 a.m.	**General Surgeons,** Florida Association of, Breakfast	Gaucho Room (Section)
	Orthopedic, Florida Society of, Business Meeting	Bal Masque Room
9:00 a.m.	**Anesthesiologists,** Florida Society of, Board Meeting	Heather (Balmoral)
	General Practice, Florida Academy of, Board of Directors	Room 207
	Health Officers, Florida Society of, Scientific Meeting	Eastward Room
	Pathologists, Florida Society of, Business Meeting	Rooms 202-203
	Plastic and Reconstructive Surgery, Florida Society Business Meeting	Room 201
	Proctologic, Florida Society of Business Meeting	Room 206
	Psychiatric, Florida Society of Business Meeting	Floridian Room
	Surgeons, American College of Business and Scientific Meetings	Grand Ballroom
	Woman's Auxilary	
	Post-Convention Board Meeting	Yucatan-Aztec Room
10:00 a.m.	**Allergy,** Florida Society, Business Meeting	Rooms 204-205
	Internal Medicine, Florida Society of, Business and Scientific Meetings	Medallion Room
	Ophthalmology and Otolaryngology, Florida Society of, Business Meeting	Caribbean Suite
	Orthopedic, Florida Society, Scientific Meeting	Bal Masque Room
12:00	**Internal Medicine,** Florida Society of, Luncheon	Gaucho Room
	Orthopedic, Florida Society, Luncheon	Bal Masque Room
12:30 p.m.	**Chest Physicians,** American College of, Florida Chapter, Luncheon	Embassy (Balmoral)
	Surgeons, International College of, Florida State Surgical Division, Luncheon	Medallion Room
1:00 p.m.	**Allergy,** Florida Society, Scientific Meeting	Rooms 204-205
	Obstetric and Gynecologic, Florida Society, Luncheon, Executive Committee	Gaucho Room (Section)
	Ophthalmology and Otolaryngology, Florida Society of, Scientific Meeting	Caribbean Suite
	Plastic and Reconstructive Surgery, Florida Society of, Scientific Meeting	Room 201
1:30 p.m.	**Chest Physicians,** American College of, Florida Chapter, Business Meeting	Embassy (Balmoral)
	Surgeons, International College of, Florida State Surgical Division, Business Meeting	Medallion Room
2:00 p.m.	**Anesthesiologists,** Florida Society of, Business Meeting	Heather (Balmoral)
	Chest Physicians, American College of, Florida Chapter, Scientific Meeting	Embassy (Balmoral)
	Health Officers, Florida Society, Business Meeting	Eastward Room
	Neurosurgical, Florida Society, Business and Scientific Meetings	Room 207
	Pathologists, Florida Society of, Scientific Meeting	Rooms 202-203
	Pediatric, Florida Society, Scientific Meeting	Pan-American Room
	Psychiatric, Florida Society, Scientific Meeting	Floridian Room
	Surgeons, International College of, Florida State Surgical Division, Scientific Meeting	Medallion Room
	Surgeons, Florida Association of General, Scientific and Business Meetings	Grand Ballroom
	Urological, Florida Society, Business and Scientific Meetings	Westward Room
2:30 p.m.	**General Practice,** Florida Academy of, Scientific Meeting	Bal Masque Room
	Obstetric and Gynecologic, Florida Society, Business Meeting	Gaucho Room
3:00 p.m.	**Industrial and Railway Surgeons,** Florida Association of, Business Meeting	Room 206
4:00 p.m.	**General Practice,** Florida Academy of, Business Meeting	Bal Masque Room
4:30 p.m.	**Pediatric,** Florida Society, Business Meeting	Pan-American Room
6:30 p.m.	**Internal Medicine,** Florida Society of, Social Hour	Yucatan-Aztec Room
	Neurosurgical, Florida Society, Social Hour	Carioca Terrace
	Ophthalmology and Otolaryngology, Florida Society of, Social Hour	Caribbean Room
	Orthopedic, Florida Society, Social Hour	Starlite Patio

	Psychiatric, Florida Society, Social Hour and Dinner	Floridian Room
	Surgeons, American College, Social Hour and Dinner	Medallion Room
	Urological, Florida Society, Social Hour	Westward Room
7:00 p.m.	**Pediatric,** Florida Society, Social Hour	Pan-American Room

Sunday, May 13

Morning	Registration and Exhibits	Theatre Auditorium
8:00 a.m.	Registration of Delegates	Medallion Room
9:30 a.m.	Second Session, House of Delegates	Grand Ballroom
1:00 p.m.	Post-convention Board of Governors' Meeting	Pan-American Room
	Florida Medical Foundation	Pan-American Room



Others Are Saying

Medical Saints

Doctors have never been known as good church-men. Indeed through the ages they appear to have stood aside from religious currents and practices, and tradition has stamped them as secular fellows and distinctively as men of the world, sceptics *par excellence*. It is a long and well established tradition extending down to modern times. In the seventeenth century Sir Thomas Browne, the physician of Norwich, in the opening sentence of his famous book, the *Religio Medici,* finds it necessary to mention that the popular conception of Medicine as irreligious, "the general scandal of my profession," would suggest that he, as a physician, had no religion at all. Proclaiming himself a Christian in the style of his time, in one of his Common-Place Books he writes, "Though in point of devotion and piety, physicians do meet with common obloquy, yet in the Roman calendar we find no less than twenty-nine saints and martyrs of that profession, in a small piece expressly described by Bzovius."

In a recent search for medical saints I soon found myself floundering in that field of literature known as hagiology (an ugly word, it seems to me) which deals with the lives and legends of the saints. It is a vast area of knowledge and could well occupy the life-time of a conscientious student. Beating a hasty retreat I emerged with a few facts which, if they fall short of investing an odor of sanctity, give the profession a faint tinge of respectability in the ecclesiastical sense.

First of all, Fletcher,* after much toiling in the thickets of saintly history, finds that there have been forty physicians among the canonised saints. Most of these elect are dim figures in obscure corridors of history. At the present day one may say that there are three saints in the medical calendar whose names are kept alive through various associations.

The first is St. Luke, called by St. Paul "the beloved physician" (Colossians IV, 14), the author of the third Gospel and the Acts of the Apostles. Luke was a Gentile, a man of education, a good historian and the trusted companion of St. Paul. There is a slender tradition that Luke was as well a skilled artist.

The other two are the Arab brothers, St. Cosmas and St. Damian, the patron saints of medicine throughout the Western world from the earliest Christian times. More particularly they were the patron saints of the barber-surgeons at a time when each guild claimed a presiding deity. Today their figures appear in the coat of arms of the Royal Society of Medicine.

Cosmas and Damian, the sons of Christian parents and physicians, lived at Aegae in Cilicia, an ancient Roman province in south-east Asia Minor. They were arrested as Christians, tortured and beheaded in the persecution under Diocletian, about 303 A.D. Their relics were brought to Rome

*On Some Diseases Bearing Names of Saints, Robert Fletcher, "Bristol Medico-Chirurgical Journal." 30:295, 1912.

and an important church dedicated in their honor. Three churches, two in Kent and one in Sussex, are dedicated to these saints. The Guild of St. Luke, St. Cosmas and St. Damian, an association of doctors and medical students, keeps their memory alive in our midst today.

Less celebrated is the physician-saint, St. Pantaleon of Nicomedia, physician to the Roman emperor, Galerius Maximian who suffered martyrdom in 305 A.D.

One also finds many saints who were not themselves physicians but who were claimed to cure certain diseases or, in some circumstances, more strangely, to inflict them as a punishment for worldly lapses. I came across an instance some months ago while visiting Dubrovnik, the ancient republic-city of Dalmatia in the modern state of Yugoslavia. Over the main gate of the magnificent twelfth-century walled city stands a fine life-size statue executed by the great modern Yugoslav sculptor, Mestrovic. I was informed by my local professor-guide that this was a statue of St. Blaise, the ancient patron saint of the city of Dubrovnik, who was a physician. Duly impressed, I gained at the time a new respect for the fine old Roman-Slavic city. However, following up the matter further, I found that St. Blaise was not a doctor, but a bishop of Dalmatia who lived in the fourth century. The legend goes that one day he met a woman and her small child, the latter choking on a bone stuck in his throat. St. Blaise laid his hands on the child's throat and the child was healed. Hence there arose the good man's reputation for curing sore throat, and subsequently toothache.

Because, I suppose, these two disorders were so common, Blaise became a popular saint. He apparently visited England, and in Cornwall where he is supposed to have landed there is a little village, St. Blazey, named after him. For centuries his day was an important festival in Yorkshire and in Suffolk.

Today he survives not only as the reigning deity of Dubrovnik but, in the delightful chronology of such things, as the patron saint of actors (because, I am told, he cures that plague of all actors, a sore throat). On St. Blaise's Day the priest still blesses actors in the Green Room of their theatre, and in some English churches, children's throats are touched and blessed by the parish priest on the same day.

And so it goes. It would seem, as some one has said, that old saints, like old soldiers, never die; they simply take on new life and carry on wearing the trappings of legend, ancient and modern. Thus medicine with its fading aura of chemistry, alchemy, mathematics and astrology, is also not without a touch of the benefit of clergy.

Group Practice
Journal of the American Association of Medical Clinics
July 1961

News

Dr. Leonard W. Larson of Bismarck, N.D., president of the American Medical Association, was guest of honor and principal speaker at a joint meeting of the Pinellas County Medical Society and the Hillsborough County Medical Association on March 5 in Tampa.

Dr. J. Maxey Dell Jr. of Gainesville has been elected to the Executive Committee of the Board of Chancelors of the American College of Radiology.

Dr. Robert E. Zellner of Orlando, President-Elect of the Florida Medical Association, will extend the official greetings of the Association to the Florida Bar at its annual meeting on April 26-28 at Hollywood.

Dr. Donald P. White Jr. of Jacksonville has been reappointed to the State Advisory Council of the Florida Development Commission by Governor Farris Bryant.

Dr. M. Jay Flipse of Miami has been appointed chairman of the Committee on Resident Loan Fund of the American College of Chest Physicians. The Committee has jurisdiction of a fund providing for loans to resident physicians to stimulate interest in postgraduate study of chest diseases and to assist postgraduate students in continuation of studies in diseases of the chest.

"The Pied Piper of Peru," an autobiographical account of the fight against yellow fever and bubonic plague in Peru from 1919 to 1922 by the late Dr. Henry Hanson, a former state health officer, is available from the Florida Public Health Association, P. O. Box 210, Jacksonville 1. The Association, together with the State Board of Health and the Rockefeller Foundation, is sponsoring publication of the book.



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NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinol, Acta Gastraent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastraent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.: Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastraent. 35:628-633 (June) 1961.

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Research in the Service of Medicine

Dr. Allen Y. Delaney of Gainesville, president, has announced that the Florida Thoracic Society will meet at Miami Beach on May 21.

A new research grant of more than a quarter of a million dollars has been received by the University of Miami School of Medicine from the National Institutes of Health, according to announcement by Dr. Edward W. D. Norton, Acting Dean. Dr. Norton stated that the fund would be used to expand the programs of student research and to establish pilot studies in several fields.

Dr. James N. Patterson of Tampa, a member of the American Board of Pathology, was in Chicago the last of February to attend a meeting of the Board and the Congress on Medical Education.

The series of six lecture-discussion meetings, entitled "Blue Print for Best Living," sponsored by the Interest Group of the Social and Economics Issues Committee of the American Association of University Women and conducted by Dr. Frederick L. Patry of Bradenton at Palmetto ended March 14. The panel discussion on February 28 on the subject, "Community Mental Health Problems and Services," featured as guest discussant Dr. Wayne Yeager of Jacksonville, Director of the Bureau of Mental Health of the Florida State Board of Health.

A new program designed to prepare nurses for teaching in schools of nursing has been initiated by the University of Florida at Gainesville as part of an overall state project sponsored by the W. K. Kellogg Foundation for the improvement of nursing education and nursing services with the emphasis on Junior College Nursing Programs. Complete information on the program is available from Medge Sledge, Ed.D., Associate Professor in the College of Nursing at the University.

Dr. Herbert E. Kaufman has assumed his duties as head of the Division of Ophthalmology at the University of Florida College of Medicine. Dr. Kaufman came to Gainesville from Boston, where he was in charge of the uveitis clinic at the Massachusetts Eye and Ear Infirmary. Previously he had served on the staff of the National Institutes of Health at Bethesda, Md., and was engaged there in extensive work on toxoplasmosis.

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1 "significant hearing improvement" occurred with Arlidin in 32 of 75 patients with recent onset hearing impairment due to labyrinthine artery ischemia.
Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

3 Arlidin "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.
Seymour, J. C.: Laryngology & Otology 74:133, 1960.

Under his direction the Eye Clinic and Ophthalmology Teaching Service of the College of Medicine is beginning its residency program and is now accepting patient referrals.

Meetings

April

Post Graduate Cardiac Surgical Colloquia, April 14 and April 28, Pathology Conference Room, Jackson Memorial Hospital, Miami

Symposium on Clinical Allergy, April 19-21, Mound Park Hospital, St. Petersburg

May

Florida Medical Association, 88th Annual Meeting, May 10-13, Hotel Americana, Miami Beach

Seventh Biennial Cardiovascular Seminar, Heart Association of Greater Miami, May 17-19, Eden Roc Hotel, Miami Beach

Florida Association of Blood Banks, Sixteenth Annual Meeting, May 18-20, Cherry Plaza Hotel, Orlando

Florida Thoracic Society, May 21, Deauville Hotel, Miami Beach

American Thoracic Society, Medical Sessions, May 21-23, Deauville Hotel, Miami Beach

June

American Medical Association, Annual Meeting, June 24-28, Chicago

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2 vascular insufficiency of the labyrinth is an important etiologic factor in sudden perceptive deafness . . . "vasodilators [Arlidin] are of considerable value."

Wilmot, T. J. and Seymour, J. C.: Lancet 1:098, 1960.

4 early cases of sudden perceptive deafness should be treated by immediate stellate block "supplemented by the most effective vasodilator drug [Arlidin] . . . energetic measures to retain blood supply to the inner ear are imperative."

Wilmot, T. J.: J. Laryngology & Otology 73:466, 1959.

in impaired hearing, tinnitus, vertigo . . .

when due to ischemia of the inner ear . . .

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Clinical benefit in approximately 50% of cases of recent onset hearing loss treated with adequate vasodilator and other supportive therapy is also reported by Sheehy.

Sheehy, J. L.: Laryngoscope 70:885, 1960.

NOTE—before prescribing Arlidin the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects and contraindications, etc.
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Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

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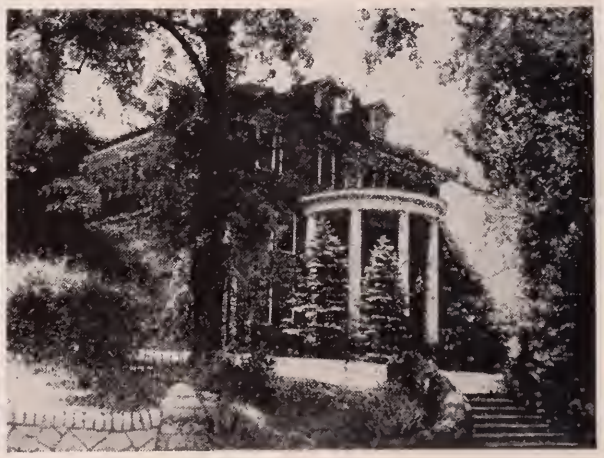
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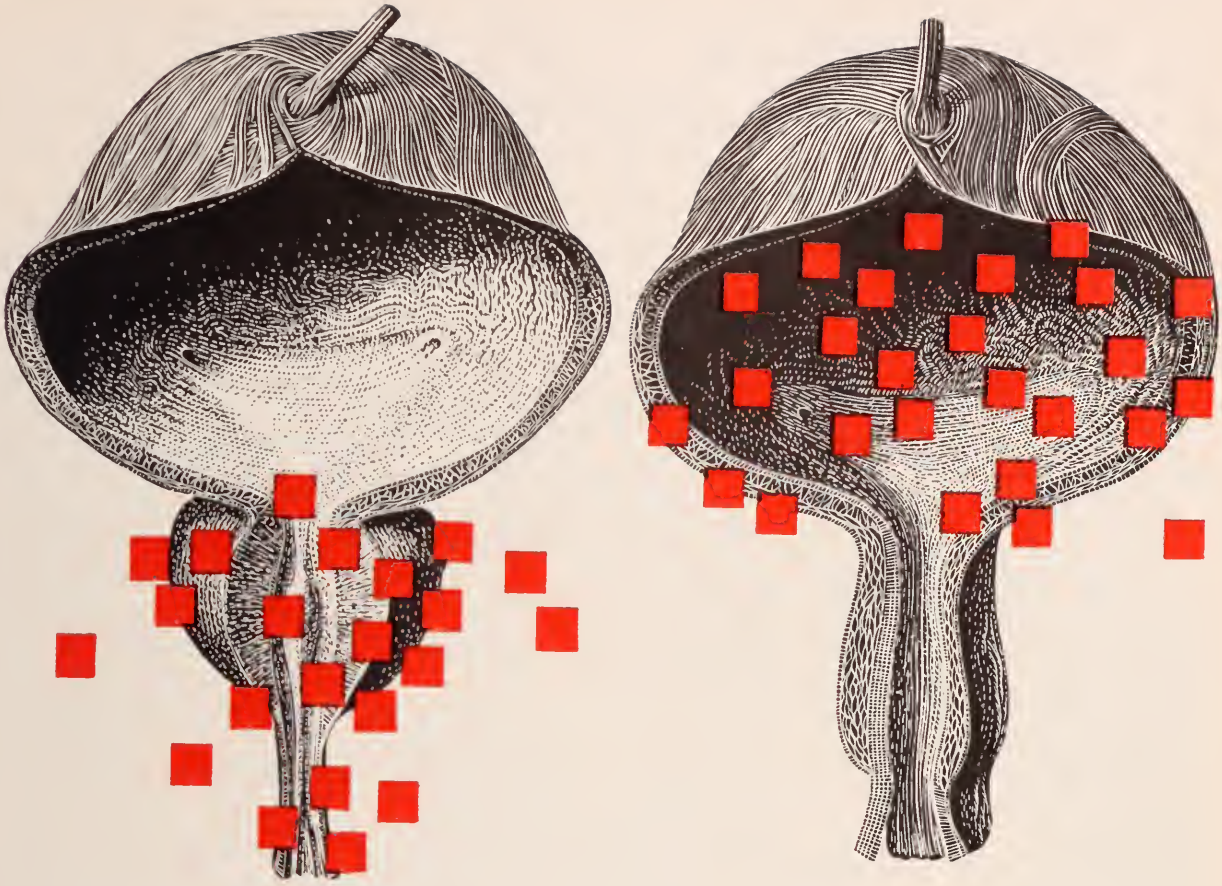
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Book Reviews

The Cardiac Arrhythmias. By Brendan Phibbs, M.D. Pp. 128. Illus. 144. Price $7.50. St. Louis, The C. V. Mosby Company, 1961.

This small volume was written for the noncardiologist physician who might be called upon to treat rhythm disturbances, particularly the more serious ones, in which the proper treatment is a matter of life and death. The author has held to his purpose remarkably well. The discussion is simple, understandable, and in general fairly complete, although in writing for noncardiologist physicians for whom the book is intended, he has necessarily had to omit much of the technical discussion usually found in most books on electrocardiography. The book is recommended for general practitioners and anesthesiologists who think that they need further skill in interpreting rhythm disturbances and electrocardiograms and in treating patients with these disturbances.

There is little in the book that would appeal to the average cardiologist. In fact, there are some parts with which the cardiologist might take issue; on page 42, under the treatment for ventricular premature beats, the statement is made, "Do not use digitalis or any of the related glucosides." While this is generally true, premature beats associated with congestive heart failure will frequently disappear under proper digitalization. In discussing the clinical diagnosis of ventricular tachycardia, the varying intensity of the first heart sound when atrial contraction just precedes the ventricular contraction is not sufficiently emphasized. In the treatment of paroxysmal atrial fibrillation, the use of rapid digitalization in converting the rhythm disturbance to normal is also not emphasized, yet this has proved to be the simplest and most effective method of conversion, particularly in elderly people.

These criticisms are actually small points and are not intended to detract from the over-all excellence of the book for the purpose that the author intended it. It is recommended for anyone not having sufficient training in cardiology or electrocardiology who may be called upon to treat cardiac rhythm disturbances.

Addison L. Messer, M.D.

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The following doctors have joined the State Association through their respective county medical Societies.

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Rush, Elizabeth A., Bonita Springs
Vickery, Robert E., Bonifay
von Ruckteschell, Arno, Punta Gorda
Watters, Vernon G. Jr., Sebring

Associate

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References: 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. Steigmann, F.: Am. J. Nursing 61:49, 1961.

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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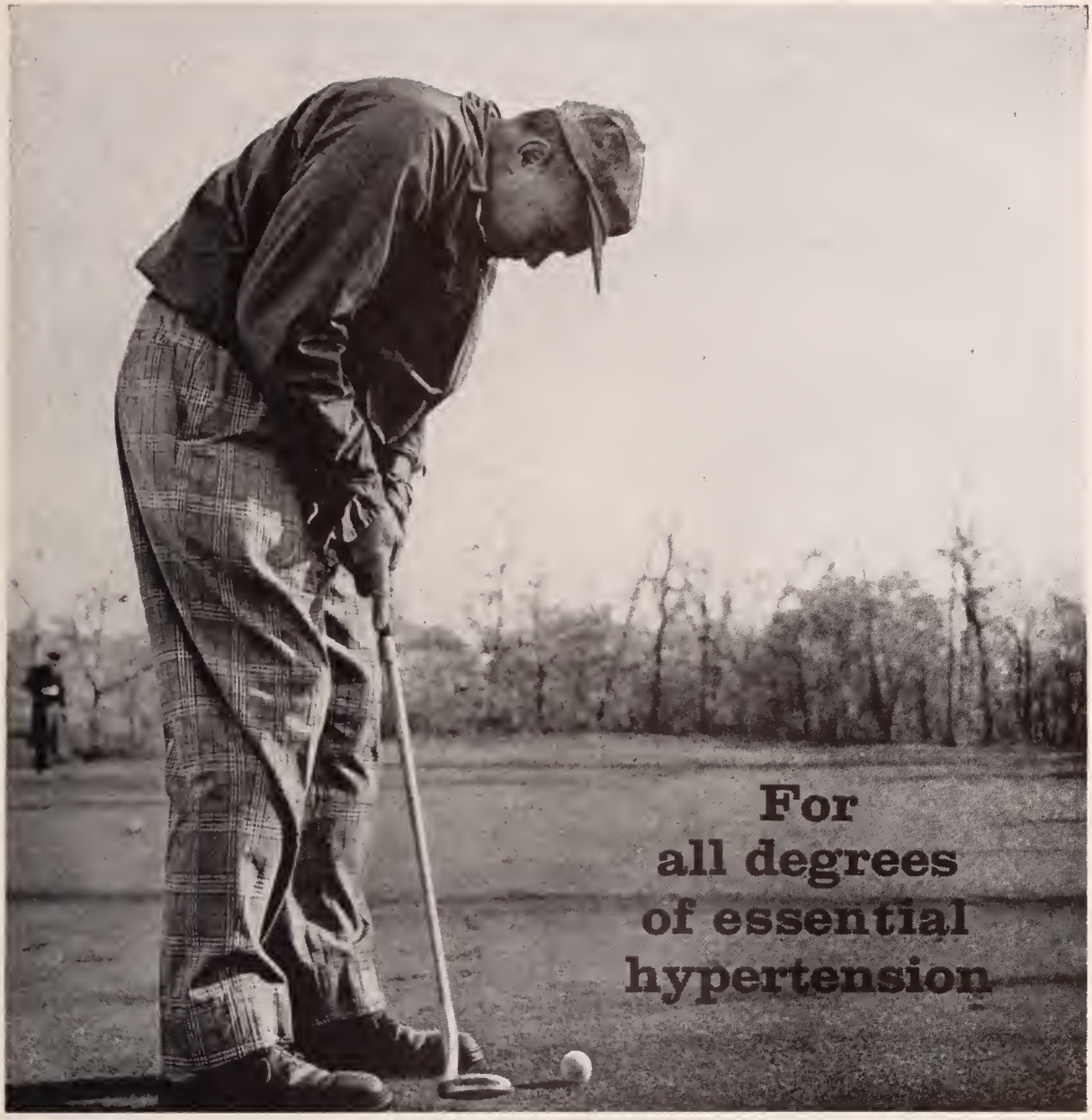
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†Hutchison J. C.: Current Therap. Res. 2:487 (Oct.) 1960.

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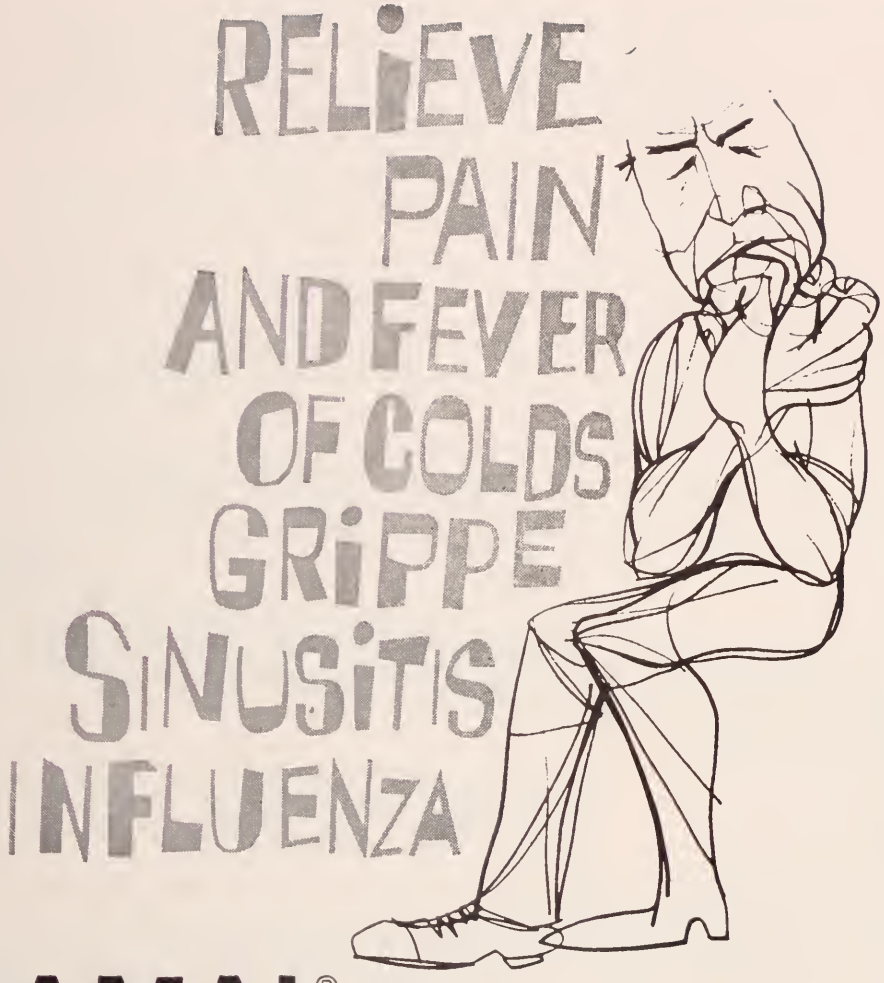
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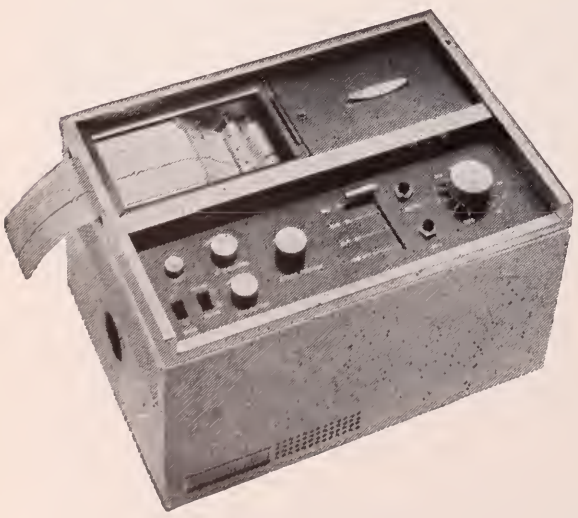
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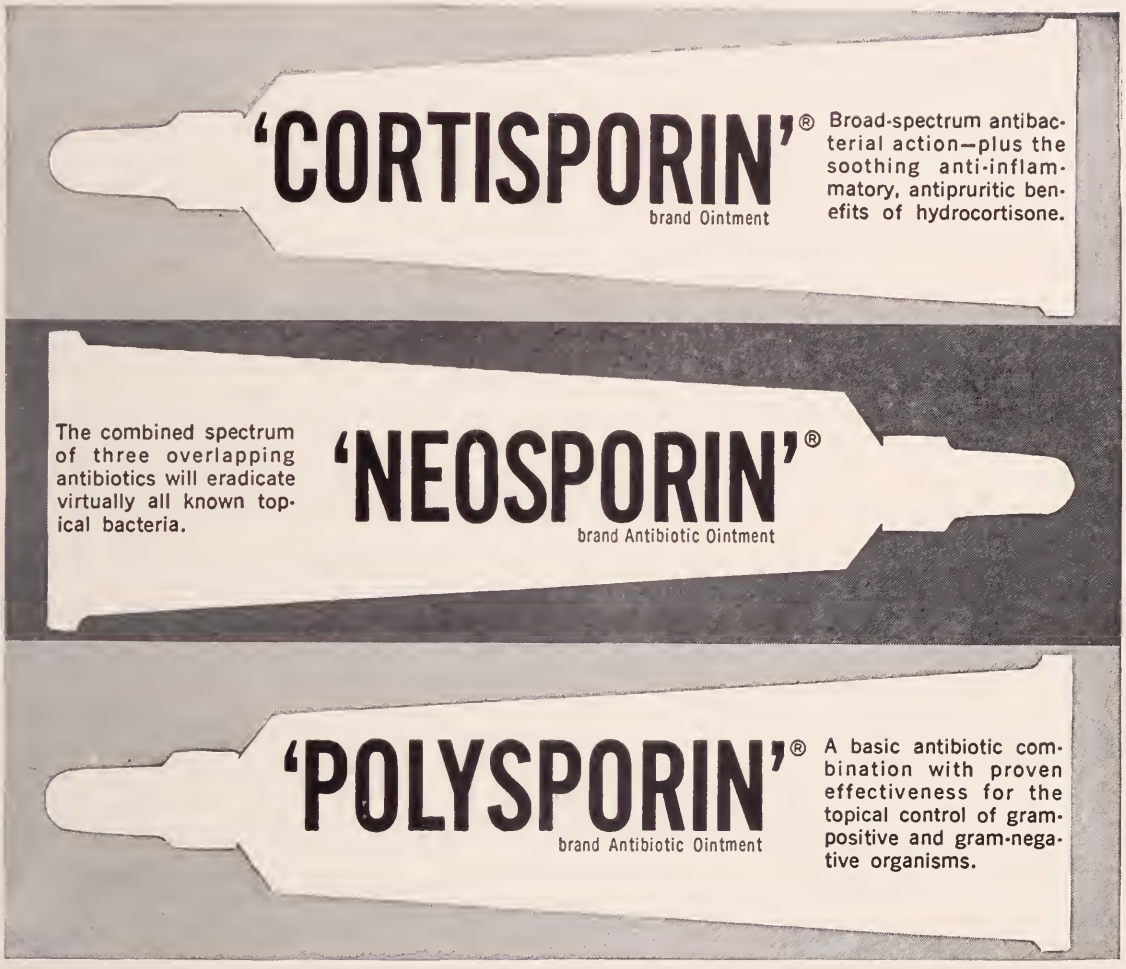
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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W and Fong, T C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

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8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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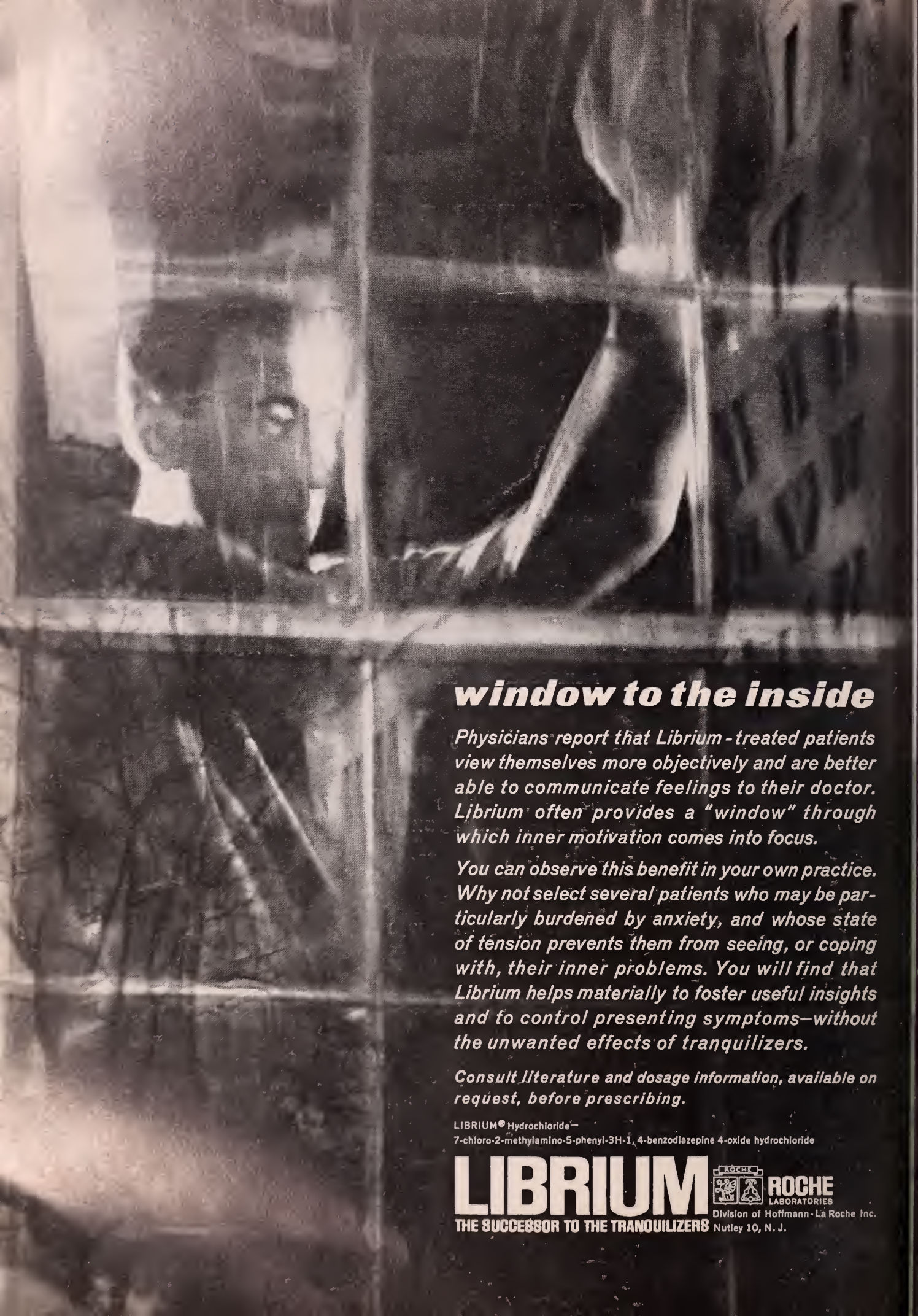
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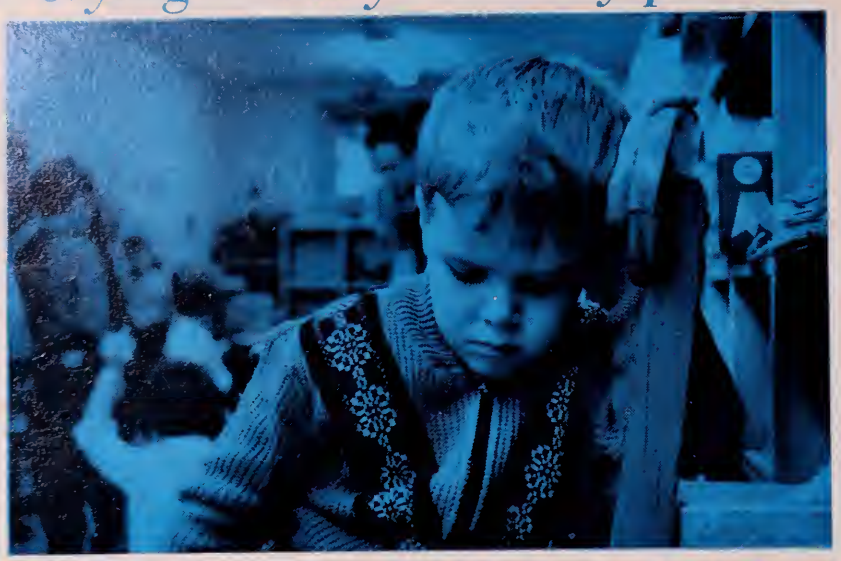
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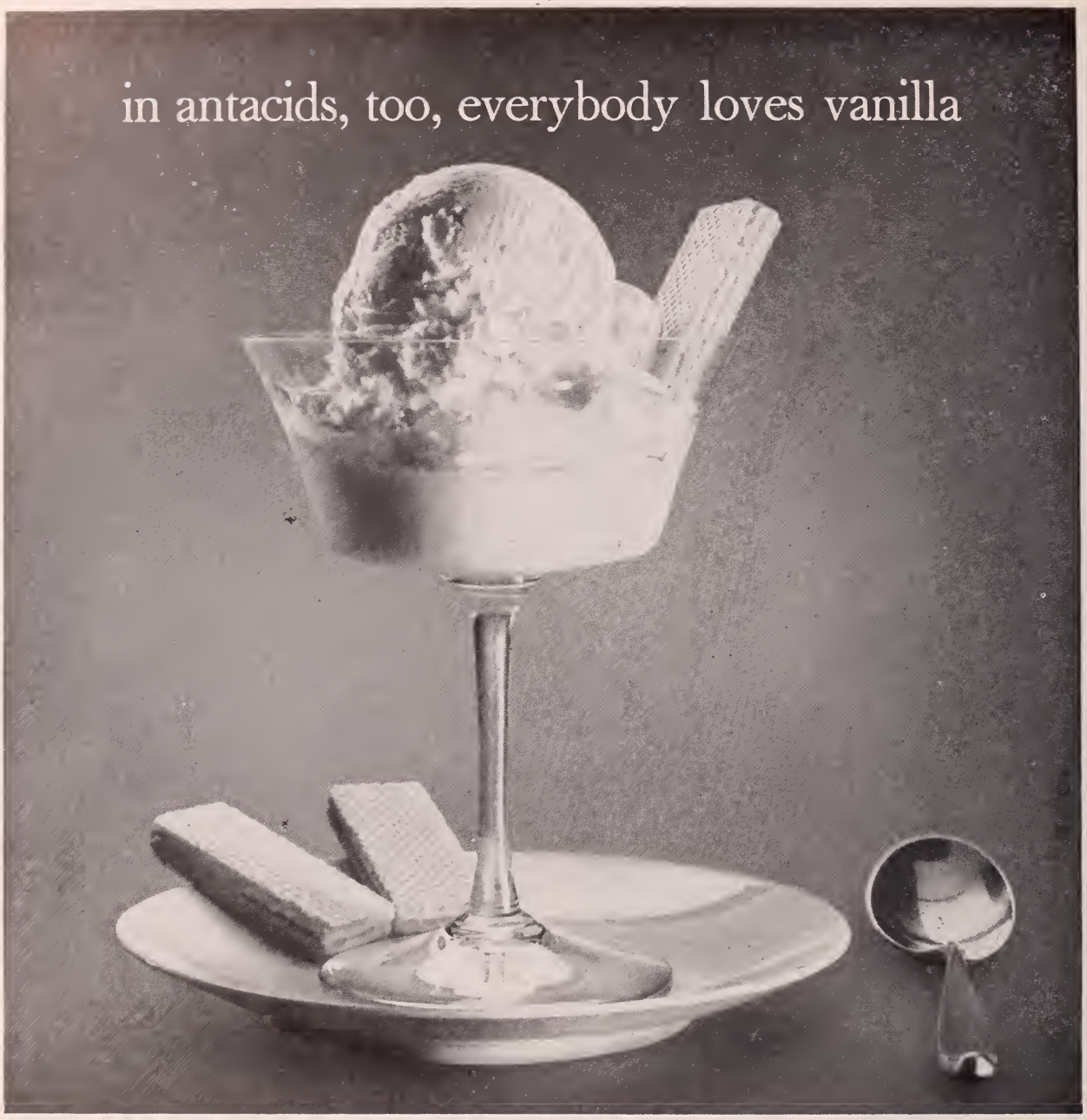
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1. Sollmann, Torald: A Manual of Pharmacology, W. B. Saunders Company, Philadelphia, 1957, p. 202.

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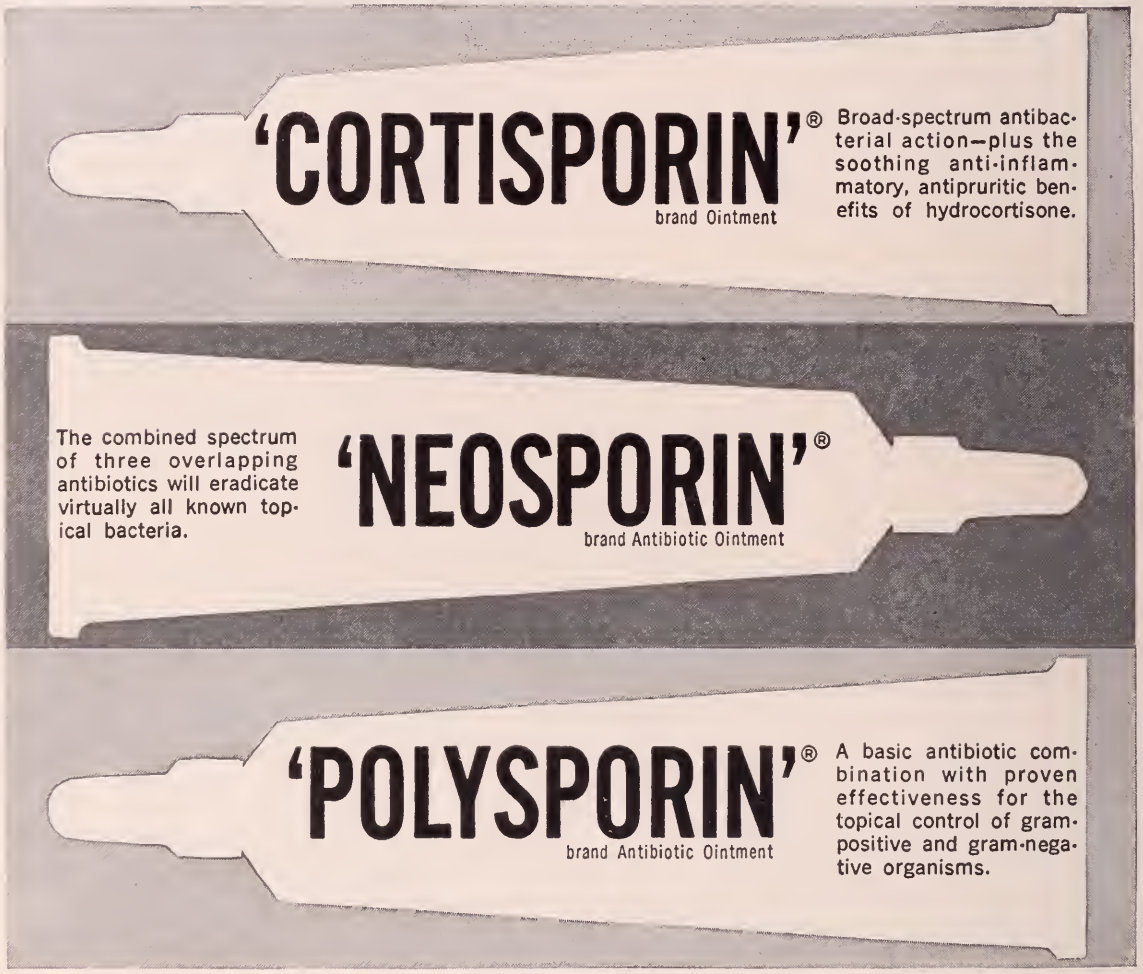
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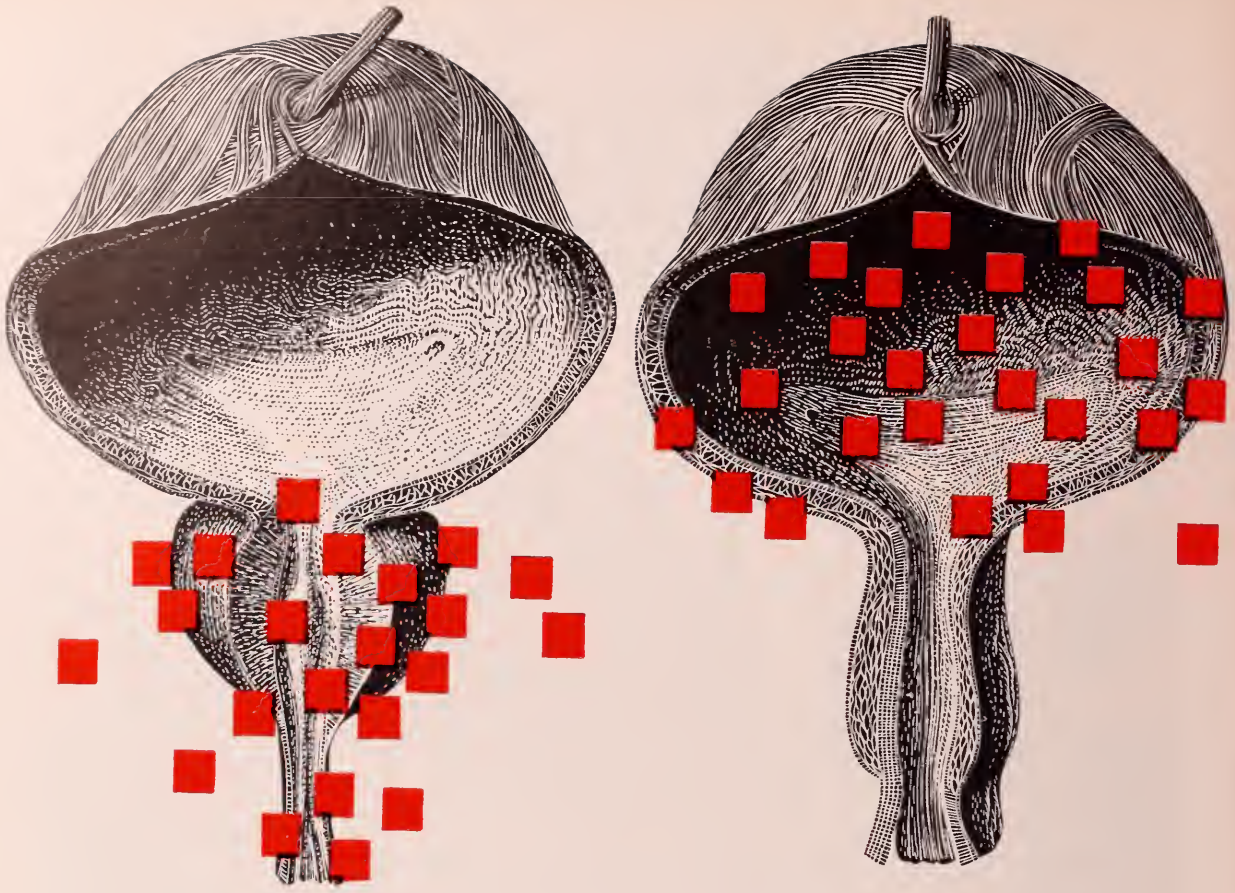
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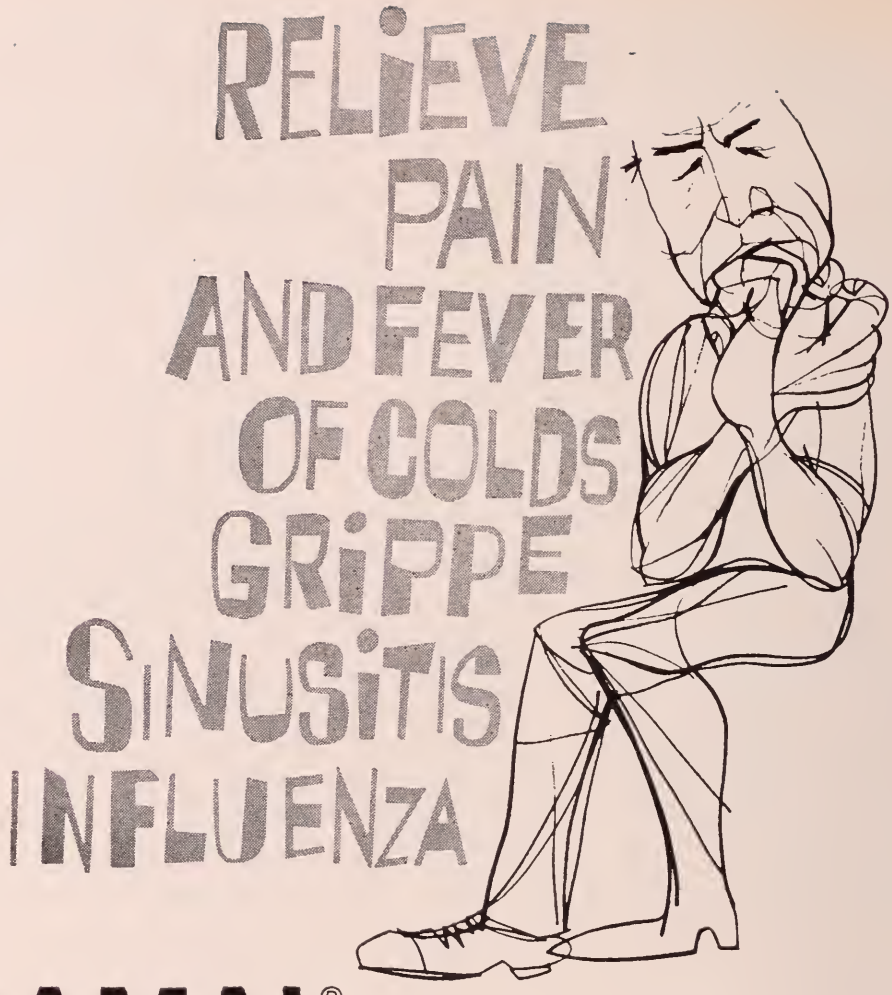
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THE JOURNAL
OF THE
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Volume XLVIII, No. 11, May, 1962

Traumatic Pneumocephalus
A Fortuitous Circumstance
With Case Report

IRWIN PERLMUTTER, M.D.
CORAL GABLES

Dandy,[1,2] who earlier had devised ventriculography, was so impressed with the chance finding of the roentgen visualization of the cerebral ventricular system caused by the traumatic introduction of air into the subarachnoid spaces and its migration into the ventricles that he compiled 25 cases from the literature and added three more in 1926. Traumatic pneumocephalus, its causes, complications and treatment, are well documented in this work. Since that time it has been the subject of numerous other publications.[3-5] Among others, a collection of 31 cases, observed by Tönnis and Frowein,[6] together with a summary of literature, was presented in 1952.

Persistent cerebrospinal fluid leak, infection, flap valve action and accumulation of excess air are the usual untoward concomitants of traumatic pneumocephalus. What is believed to be an adequate search through the available literature fails to reveal the combination of circumstances to be related here, in which a traumatic pneumoencephalogram became a vitally important diagnostic aid.

Report of Case

A 14 year old, right-handed boy was admitted to the South Miami Hospital on Jan. 6, 1961, following an automobile accident. In the emergency room he was drowsy, but could be roused to respond verbally. He was disoriented to time, place and person. The blood pressure was 114/70 mm. Hg, the pulse rate 88 per minute and the respirations 20 per minute. There were abrasions over the right and left side of the head and blood in the nares and left ear. The neck was supple. The carotids pulsed normally.

The testable cranial nerve functions appeared intact except that the left eye could not be completely turned laterally on command. The extremities moved well. He felt pin prick throughout. The cerebellar tracts appeared undisturbed. The reflexes were present, equal and active, and no abnormal responses could be elicited. He vomited old and fresh blood. It was the impression that he had a contused brain and abrasions and contusions of the scalp as well as a contusion of the abducens nerve on the left side.

X-rays of the skull were made with the patient on the stretcher between the emergency room and his hospital room. The three views shown in figure 1 demonstrate the presence of air in the left lateral ventricle and also small quantities of air in the subarachnoid and subdural regions.

The patient was given prophylactic antibiotics and carefully observed. The next morning, weakness of both the upper and lower right facial musculature was noted, but he was more alert and complained of double vision. Shortly after drinking ginger ale at about noon time, he began to complain of severe headache. He vomited, became "noisy and restless" and in only a very few minutes became "comatose."

Immediately upon this sudden change of condition, he was sent, via the x-ray department, to the operating room. The anesthesiologist's note at this point is interesting: "Patient seen in elevator on way to operating room. Patient was cyanotic, respirations four per minute, mouth filled with blood. Intubated immediately in operating room hall and taken to surgery."

At just this time the x-ray of the skull (fig. 2) taken on his way to surgery was brought into the operating room. This anteroposterior view showed the air-filled left lateral ventricle shifted across the mid-line to the right. This x-ray and the progress of events were characteristic of extradural hematoma on the left side, which was found and removed. The actively bleeding middle meningeal artery, under a left temporoparietal fracture line, was coagulated. This x-ray did not show an increase in the quantity of air in the skull, which complication of pneumocephalus might just as well have caused the reported progress of events.

Following the operation the boy made a gratifying recovery and was discharged ambulatory from the hospital on January 21. At the time of discharge a complete right facial palsy, a left abducens palsy and minimal weakness and spasticity of the right lower extremity were present. Figure 3 shows the return of the left lateral ventricle to its normal position, following evacuation of the large left extradural hematoma. The cranial defect in the left temporal region is also visible.

The boy was followed as an outpatient and was last seen on March 13. A pulsatile, concave, bony defect was

Clinical Associate Professor of Neurosurgery, University of Miami School of Medicine, Coral Gables.

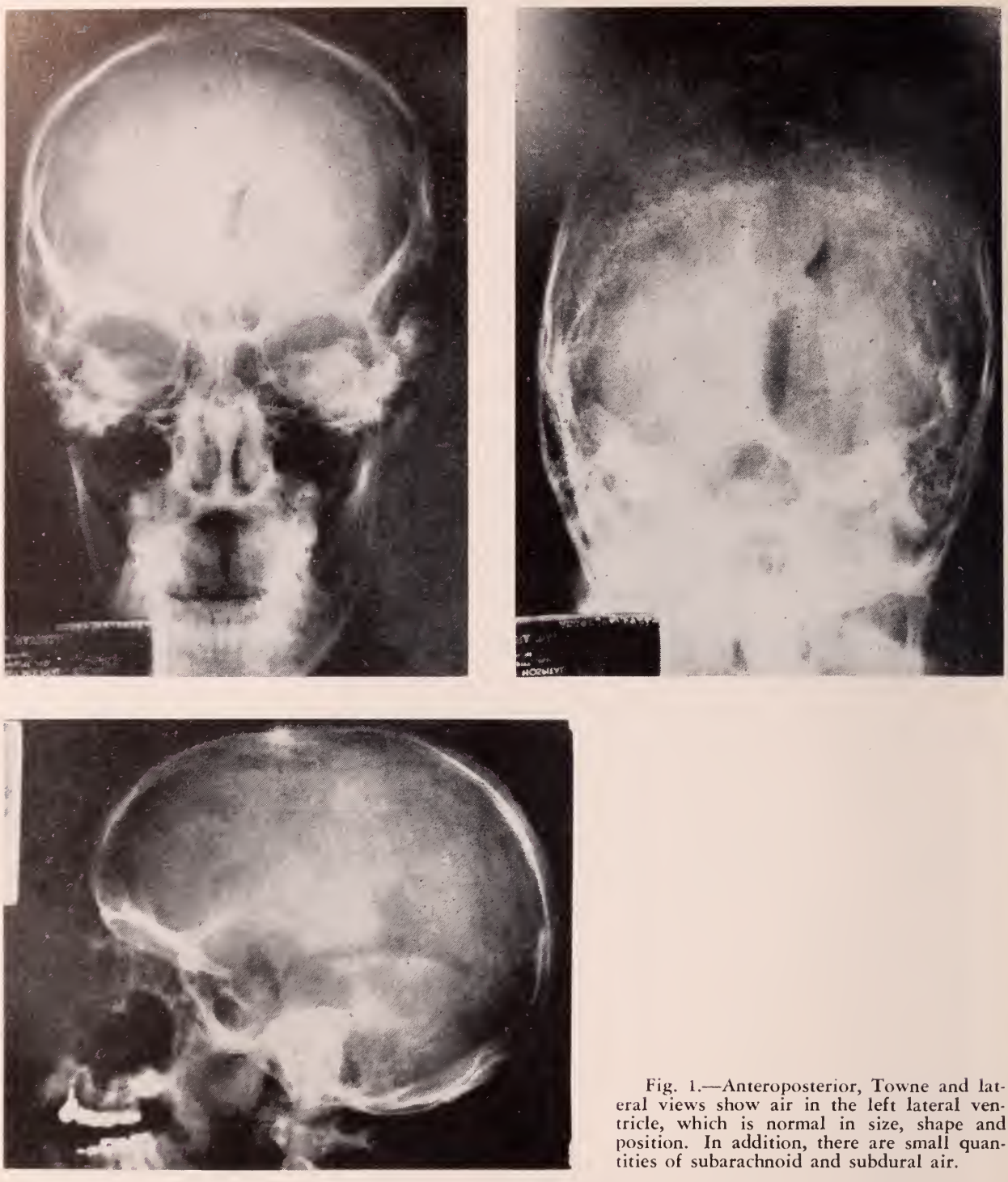


Fig. 1.—Anteroposterior, Towne and lateral views show air in the left lateral ventricle, which is normal in size, shape and position. In addition, there are small quantities of subarachnoid and subdural air.

present in the left temporoparietal region. The complete right facial weakness was beginning to resolve as was the left abducens weakness. The weakness and spasticity of the right lower extremity had completely disappeared. The boy had been riding his bicycle and had returned to school.

No cerebrospinal rhinorrhea or otorrhea had appeared. It is believed that the pneumocephalus resulted from a fracture in the right mastoid region. This fracture is probably the reason for the delayed facial palsy on the right as well.

Discussion

The untoward effects of the circumstances leading to traumatic pneumocephalus, and the complications thereof, are the usual subjects of the works of the various contributors to the literature on the subject.

In the case here described, the chance finding of traumatic pneumocephalus was utilized constructively. The usual complications of pneumocephalus were first carefully considered and measures were adopted to combat their possible appearance. Then the dynamics of the pathophys-



Fig. 2.—Anteroposterior view showing the air-filled left lateral ventricle shifted across the mid-line to the right.



Fig. 3.—View showing the left lateral ventrical returned to its normal position after evacuation of a large left extradural hematoma, and also the cranial defect in the left temporal region.

iology were put to useful purpose when the patient's condition deteriorated.

It was most fortunate for the patient, and indeed it was almost cooperative of him, that he had traumatic pneumocephalus as it gave the cause and localization of his subsequent difficulty. This fortuitous circumstance allowed the immediate approach to the problem. It is important, therefore, not only to be concerned with traumatic pneumocephalus and its possible untoward sequelae and to parry their assaults, but also to take advantage of the visualized ventricles and, if the opportunity exists, riposte.

It has been said that in cases of head injury, immediate x-rays of the skull are really not an essential part of the examination of the patient, but it has been the habit of many,[5] however, to send patients with such injury from the emergency room, via the x-ray department, to their rooms. Certainly this policy was vindicated in this case.

Summary

A case of traumatic pneumocephalus complicated by extradural hematoma is presented.

Traumatic pneumocephalus was turned to good use to make an accurate diagnosis in this case.

It is emphasized that it is essential to be able to think offensively as well as defensively and to capitalize on any mistakes of the enemy.

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Volume XLVIII
Number 11

Safety Lens Materials

Thomas G. Dickinson, M.D.
SARASOTA

The use of safety lens materials in spectacles for the prevention of ocular injuries has been regarded with far too little emphasis when compared with the progress made in other fields of medical practice.

Dr. Arthur Keeney, of the University of Louisville School of Medicine, succinctly pinpointed the problem when he stated, "The use of spectacles is so ordinary that, like automobiles without seat belts, their very commonplace appearance in thousands of numbers about us belies their deadly potential." Well over 75 per cent of the adult population, if not glassed all the time, uses spectacles at one time or another during the wakeful hours. This percentage, of course, increases with each decade of life. The more appalling, or I would say hair-raising, statistic is that over 95 per cent of these spectacles are made of brittle, easily fractured crown glass.

We, as physicians in the state of Florida, would be alarmed if it were reported to us that there were three cases a month in our state of postoperative panophthalmitis, and at least one of these three each month resulted in a lost eye. In 1958, however, a survey of ocular injuries in this state from broken spectacle lenses revealed 36 cases, an average of three a month. Ten of these resulted in industrial blindness. Fourteen were caused by flying objects, such as nails, rocks, and baseballs; simple falls accounted for two cases; and three occurred in automobile wrecks. This ocular carnage could have been prevented by simply preparing spectacle lenses in safety materials rather than in crown glass.

Materials Currently Available

Current safety materials available can be divided into three classes: (1) laminated glass; (2) heat-treated or hardened glass; and (3) organic plastics.

Laminated glass, although superior from the safety point of view to plain crown glass, carries with it two rather significant disadvantages which have prevented it from attaining the general acceptance that heat-toughened glass and organic plastics have attained. First, in spite of advancement in edge-sealing techniques and the introduction of polyvinyl butyral as a midlayer, interlayer breakdown still occasionally occurs, with noticeable "running" towards the edges of the lens. Secondly, on drop ball testing and on bombardment with low velocity missiles, these lenses fracture at essentially the same resistance point that ordinary crown glass does. The layers of the glass would in general bind together fairly well, but small spicules and particles would often fly from the inner surface of the lens. These particles create a definite hazard to the eye.

Heat-treating or heat-toughening of glass was first developed before the turn of the century at a time when processes for heat-tempering steel for armorplate were beginning to be developed. Today, the process has undergone innumerable refinements until at present a table-size heat-treating unit suitable for equipment in even the smallest of optical shops is available. The modern lens is heat-treated after the process of polishing and edging has taken place. It is particularly important that the polishing be carefully and accurately accomplished, because fracture systems often start in an area of surface scratching or flaws. Scratched or pitted safety lenses of the heat-treated variety should be removed from service because their impact resistance has been significantly decreased. The average heat-treated lens, depending on thickness, undergoes an increase in impact resistance of from three to seven times.

The use of plastics for ophthalmic lens materials dates back about a quarter of a century to the time of the introduction of Plexiglas or Lucite. Today, optical plastics are classified according to their molecular linkage into linear polymers, which are thermolabile, or into cross-linked polymers with a three-dimensional type of structure, which are thermostable.

The linear polymers, of which Plexiglas or methyl methacrylate is an example, have excellent refractive characteristics, but are too soft for practical optical use.

The cross-linked polymers known as allyl diglycol carbonate (or CR-99) have been used

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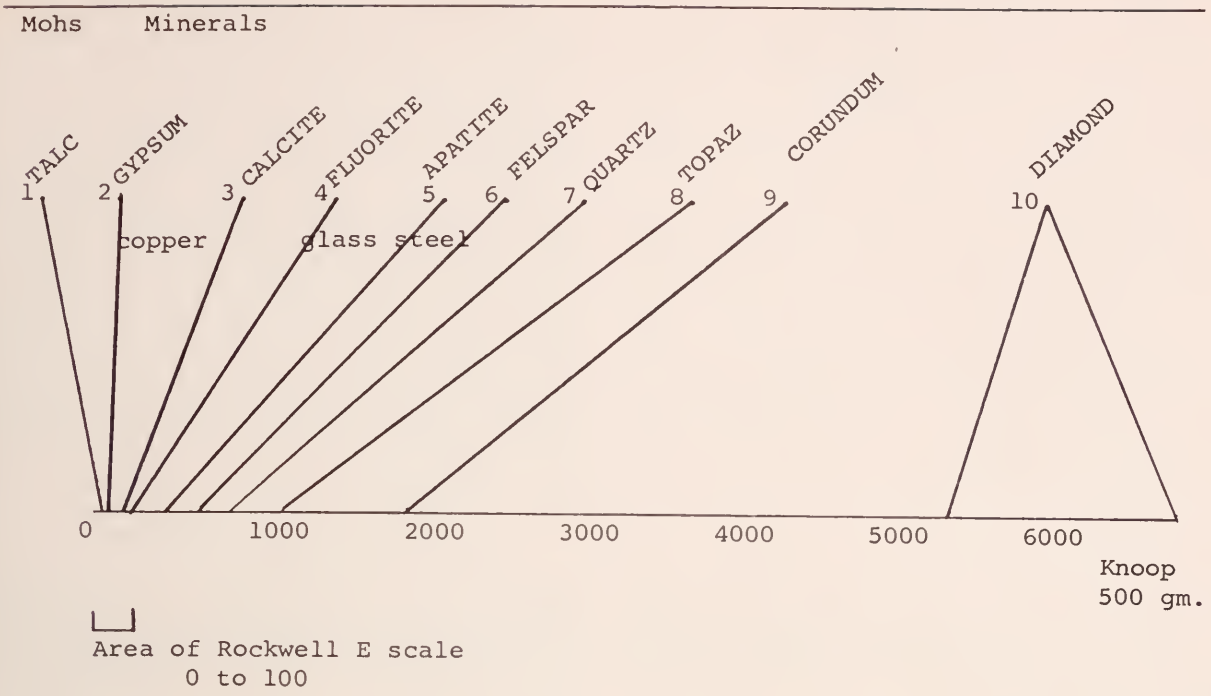


Figure 1

in the development of the harder resins which have become extremely practical for ocular use and are marketed under the various trade names of Armorlite, Enduron, Optilite-A, Plastolite, Aolite and others.

Characteristics of Safety Lens Materials

The optical characteristics of heat-treated glass, laminated glass and organic plastics are all extremely satisfactory and closely parallel the characteristics of crown glass. It is not these optical characteristics, therefore, but rather the characteristics of impact-resistance and resistance to surface scratching, as well as fracture pattern upon impact, which would influence us regarding the desirability of a material for use in spectacle lenses.

Surface hardness or scratch resistance is a minor problem in heat-treated glass lenses, but would have to be considered a significant problem in plastic lenses. Heat-treated glass, because of decreased surface elasticity, is slightly more susceptible to scratching than ordinary crown glass, and it should be repeated that surface scratching or abrasion in turn lowers the impact resistance as it opens an avenue for a fracture pattern to begin. Softness or surface scratching in the linear polymers, such as Plexiglas, exceeds the practical limits for optical use. The cross-linked polymers, however, or the allyl resins, produce much more satisfactory resistance to surface abrasions, and are in an area of practicality for use in ophthalmic lenses.

Figure 1 shows the area of hardness measured by the Rockwell E indentation test in relation to the general hardness of minerals. Table 1 shows the Rockwell E readings for various ophthalmic plastics. It will be noted that the first four under the plastic lens section are the cross-linked polymers and average in the 40's, whereas the remaining specimens are the linear linkage polymers and average in the 30's or below.

Impact resistance in ophthalmic safety materials is measured by the drop ball test, which is believed to approximate the low velocity missiles possibly encountered in civilian life. Table 2 shows the impact resistance of various safety lens materials and the 45 drop ball test. It will be noted that the first two lenses are industrial thickness plastic and glass, and that the third, which is ophthalmic thickness allyl plastic, corresponds favorably with these of industrial thickness. Ross and Stewart studied high velocity missiles and their results on ophthalmic safety lenses. Their

Table 1.—Rockwell Indentation Hardness

(Am. Society for Testing Materials, Spec D 785-51)
E Scale Values (using 100 kgm. load and ⅛" steel ball indenter)

Plastic Specimens:	Range	Average
Plexiglas II UVA (Rohm & Haas)	24 to 29	(26)
Polystyrene	−9 to −11	(−11)
Cellulose acetate	−34 to −37	(−36)
Plastic Lenses:		
Optilite A (allyl resin)	47 to 49	(48)
A-O Tillyer Plasticor (allyl resin)	44 to 48	(46)
Armorlite (allyl diglycol carbonate)	39 to 44	(42)
A-O Plastolite (allyl diglycol carbonate)	41 to 42	(42)
Plastough (Willson)	35 to 37	(36)
Enduron (Pioneer Scientific Corp.)	30 to 38	(35)
Dockson No. 11 (Plexiglas II UVA)	38 to 39	(39)
Watchemoket 440 (Plexiglas II UVA)	30 to 31	(31)
Optilite B (methyl methacrylate)	12 to 13	(12)
I-gard	2 to 10	(5)

results suggest that with a 1 mm. missile, comparison of industrial thickness heat-treated glass with rabbit corneas reveals corneal tissue to be more resistant to penetration than the lenses. The lenses broke at velocities less than the velocity required to penetrate the cornea. Allyl resin lenses similarly bombarded showed no more than a barely visible dent. Their studies, as well as those of Keeney, suggest that allyl resins afford the most consistent high impact resistance, while among the glass products, industrial thickness heat-treated glass offers the greatest low impact resistance.

When one is dealing with prescription lenses, obviously the prescription strength will alter the impact resistance; thus increasing the spherical or decreasing the cylindrical power will produce increased resistance. Similarly, more plus and less minus will have a like effect.

Fracture patterns secondary to breakage on impact are equally important as a consideration in choosing a safety lens material. Crown glass, as well as the inner layer of laminated glass, upon fracture will produce minute sharp spicules and particles capable of penetrating and perforating the afterlying globe. Similarly, case-hardened glass, although more resistant to impact, will upon fracture loose small spicules from its posterior surface. Plastic lenses, on the other hand, upon fragmentation will give off more obtuse and less damaging segments, a quality secondary to the relative softness of the plastic and which I believe offsets the mild disadvantage of surface scratching of the plastic.

Advantages and Disadvantages

The foregoing data suggest, therefore, that there are only two truly practical safety materials for ophthalmic lenses. One is heat-treated or case-hardened glass, and the other is the cross-linked polymer thermostable plastic known as allyl resin, marketed under such names as Armorlite, Opolite-A, Plastolite, Aolite and others.

Advantages of the plastic lens materials are: (1) greater impact resistance, coupled with the fact that fragmentation, when it does occur, is in larger, less dangerous particles; (2) weight 50 to 60 per cent less; (3) transmission of the visible spectrum slightly superior to that of glass; (4) less tendency to thermofogging with rapid temperature changes; (5) greater resistance to welder's spatter; and (6) replacement because of surface abrasions that would decrease impact resistance not as necessary as with glass.

The disadvantages of plastic would be: (1) its relative softness, which in my opinion is more than offset by the fact that this relative softness avoids the hazard of small dangerous particles

Table 2.—Low Velocity Impact Resistance in Relation to Lens Materials

(Drop Ball tests with 45 gram steel ball)

Plano Lenses According To Basic Material Used	Thickness	Drop Distance for Fracture
Industrial thickness allyl resins	3.4–3.6 mm.	84 in. plus
Industrial thickness, heat-treated glass	3.2–3.4 mm.	84 in. plus
Ophthalmic thickness, allyl	2.0–2.3 mm.	72–84 in. plus
B & L semi-ophthalmic thickness toughened glass (1956 quenching modification)	2.3 mm.	30–84 in. (avg. 61 in.)
Methyl methacrylate	2.9–3.4 mm.	24–64 in. (avg. 46.2 in.)
Semi-ophthalmic thickness toughened glass (Tempross)	2.0 mm.	54 in.
Crown glass, not hardened	1.9–2.0 mm.	18–36 in. (avg. 27 in.)
Transpex I ("I gard")	1.8 mm.	24 in.

or spicules upon occasion of fragmentation; (2) resurfacing or repolishing because of scratches is impractical, and makes replacement necessary; (3) these lenses can be ignited, but the ignition point is high and flammability is much less than that of most spectacles frames; and (4) the cost of plastic lenses is slightly higher than that of glass in lower strengths, but rises sharply as power is increased. It is anticipated that the increased cost of plastic lenses will be reduced as developmental expenses are absorbed and as production increases.

Conclusion

What, then, are the indications for safety lenses? I believe the one indication is the need for corrective spectacles or the desire for protective spectacles. With the possible exception of the aged and infirm, limited to a sedentary existence, I can see absolutely no excuse, much less any indication, for the use of breakable and hazardous crown glass in spectacle lenses.

I am indebted to Dr. Keeney from whose excellent monograph the table, chart and much of the material herein was taken.

1880 Arlington Street.

Problems Encountered During Fitting and Wearing of Contact Lenses

Frederick E. Hasty Sr., M.D.
CORAL GABLES

It has been stated that anyone in normal health with a strong desire can learn to wear contact lenses, thereby restoring eye health and visual function. This is a broad statement and implies a considerable obligation on the part of the ophthalmologists who perform contact lens service.

If this statement be true, we must bring about its realization by ever increasing our ability to select our patients more wisely, and then to be able to deal with the problems they encounter both during adaptation and wearing of contact lenses.

It is to this end that the discussion of evaluation and adjustment of contact lenses is directed. Evaluation and analysis of lenses are an important part of our service starting with their first insertion and lasting as long thereafter as the patient wears these or subsequent lenses. Only as application of contact lenses become more universal.

It has also been stated by experts that ophthalmologists properly equipped and trained in making all necessary adjustments except major changes in power should perform this service. The fitting, adjusting, and re-evaluation of both the lenses and the cornea are most important parts of the service, and it is for this reason that contact lenses can never be considered as a "one shot treatment."

Assuming a thorough refraction, slit-lamp examination of the cornea, and evaluation of the patient for physical and psychological fitness have been made, the lenses properly prescribed, fitted, and fabricated, we are at the point to discuss in detail some of the steps necessary to keep the patient comfortable and wearing contact lenses successfully.

General Factors

Three general factors should be mentioned and then more specific problems discussed in detail.

1. Irritation of the cornea can be caused by the patient roughly mopping the eyes, rubbing the lids, or frequently wiping the eyes. Nervous habits with the lids such as blinking, rubbing the eyes, or persistent squinting are all physical acts any patient may perform, all of which make wearing contact lenses more difficult. Ideally they should have been observed and explained to the patient before prescribing lenses.

Contact lenses frequently cause clinically quiescent meibomianitis to become active, and are not indicated for patients with this disease.

Read before the Florida Society of Ophthalmology and Otolaryngology, Miami Beach, May 28, 1961.

2. To date contact lenses have been developed largely on a mechanical basis. They are made of plastic and are subject to all the frailties of that material. We regard contact lenses of the past as being very crude objects; yet in a short time I predict those we use today will become crude in comparison with those of the future.

It is estimated that 90 per cent of problems in wearing contact lenses are associated with surface and or periphery defects that can hardly occur, and need not occur, if the lens has been properly inspected and refined prior to first insertion, even though the prescription is correct and the lens has been properly fabricated by the manufacturer.

All lenses should be inspected with high microscopic power for porosity, imperfections in polish, embedded grains of the polishing agents (which are harder than the plastic), and peripheral defects. There is a compact and inexpensive piece of projection equipment designed for this purpose by Dr. Chester Black of Chicago, which is indispensable.

Surface imperfections such as these, when detected, can be readily eliminated by proper polishing with either wet chamois or wet thin China silk over moleskin.

Shadows of lenses greatly enlarged may be projected on screen, large cardboard, or smooth wall which give one grossly enlarged views of the shapes of surfaces, edges, and bevels of surfaces. Granules of abrasive polishing agents embedded in the lens or sharp inner edges which will contact the cornea are a common cause of irritation and discomfort.

We have thus far discussed the proper evaluation of the patient and evaluation of the manufactured lens itself prior to insertion, and let me emphasize that these functions belong to the ophthalmologist himself.

3. Abrasions of the cornea occurring during insertion of the lens are a cause of much discomfort, and particularly in the new patient. Obviously, the remedy here is adequate instruction and training of the patient, particularly in the patient who has not worn lenses before.

In practice, combining a lens properly finished and shaped with a patient who does not mishandle it is the first ingredient of a successful case, and any other combination leads to trouble. Truly a lens properly shaped and finished will rarely damage an eye if it is handled properly by the wearer.

Specific Factors

More specific lens factors now must be considered, such as size, fit and curvature. They will be discussed separately in relation to the symptoms they cause and their remedy.

LARGE LENSES. A lens that is too large will extend too far beyond the limbus when it moves up or down, and Sattler's veil is likely to develop. Irritation of both lids, but particularly the lower lid, the sensation of a lash under the lid, limited lag, or movement of the lens, the "tired" feeling of the eyes, excessive tearing and mucus in the eyes in the morning are symptoms of a lens that is too large.

Findings follow this pattern: swelling in the margins of the lids, fluorescein not moving freely under the lenses, vision that may be fogged, and more serious, pitting or blebs on the cornea. The remedy is to reduce the size of the lens 1 mm. for every 2 mm. it extends over the limbus.

SMALL LENSES. A lens that is too small is difficult to keep centered over the pupil. Shifting vision, unilateral double vision, lagging too rapidly, lenses dropping from the eyes, discomfort when pencils of light hit the edge of the lens, and difficulty in removing the lenses are the most prominent symptoms of this problem. Their remedy is a larger lens.

TIGHT OR "STEEP" LENSES. A lens that is too tight, or as commonly expressed, too "steep," is likely to touch the cornea only on the thick edge, which is harmful because the lens becomes adherent or sealed to the cornea, creating a vacuum. The negative pressure within gradually lifts the superficial layers of the cornea, causing blistering. Pressures so produced can cause pressure anesthesia and loss of sensation.

These lenses are usually worn with comfort for a few hours, but after the lens is removed and sensation returns, exposed nerve endings may produce intense pain. This situation is also favorable for development of infections if contamination occurs. Should Bowman's membrane be reached by infection, serious scarring resulting in visual damage may occur, and if Bowman's membrane is perforated, eventual enucleation may be necessary.

In theory a lens floats in a layer of tears, though in practice some portions of the lens touch the cornea constantly. For this reason and the fact that these lenses may be worn without discomfort as explained, it is no exaggeration to state that the "steep" lenses are the most dangerous problem of fitting with which we are confronted.

Symptoms are changes in lag or rate of movement varying from diminished lag to none at all, stinging sensation some time after removal following comfortable wearing, and difficulty in removal of the lens.

7. Diagnostic findings are denuding of the epithelial cells from the surface of the cornea, fluorescein or tears not flowing under the lens, and the lens tending to be retained.

The remedy is first to stop wearing the lenses for a week for each day required for recovery of the cornea. In mild cases correction may require only that the posterior bevel be widened; in other cases the lens should be replaced with one which is one-half diopter flatter.

Improper Curvature. Because of the wide variation of the surface of the cornea it is necessary that lenses be shaped so that they will not fit too closely to its surface. So-called curves are cut in the lens to create space between the lens and the cornea, and this procedure is performed largely on the basis of experience and intelligent guesses, another important reason why each lens must be adjusted to each eye. There may be as many as five different curves incorporated in the same lens. The lens should be so refined and polished that the curves "blend" into each other with no surface irregularly or roughness between them. Here again, careful study and inspection of the lens prior to insertion are essential.

Problems of the Experienced Patient

The problems we have discussed are primarily concerned with new lenses, and usually with new lens patients during tolerance development. Usually these problems will be encountered with one's own patients and with one's own lenses. There are, in addition, the problems of the patient who has developed tolerance and worn lenses successfully for varying lengths of time.

Sudden severe pain is likely to be caused by a foreign body. Discomfort in both eyes may indicate keratitis. Usually there are fine multiple vesicles, little or no congestion, and profuse tearing which ceases when the lenses are removed. The conditions are stubborn, sometimes do not yield readily to treatment, and tend to recur at the slightest provocation such as dust, smoke, fumes, upper respiratory infections or allergy, or for no apparent reason. Some patients may be able to wear lenses several hours a day during such bouts, but complete cessation of lens wearing is likely the advisable course of action.

Of course, thorough lens analysis and evaluation are the first and most essential step in arriving at a differential diagnosis for these problems of keratitis.

Summary

To summarize, patient evaluation from the physical and psychological standpoint, careful examination of the cornea, and current, accurate refraction are the essential foundation of successful contact lens service. Once they are accomplished, wearing of trial lenses, correct prescription and correct lens fabrication constitute the next step. This discussion covers the many details of lens evaluation and analysis in relation to common problems encountered in developing patient tolerance and successful lens service.

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The Effect of an Oral Nasal Decongestant Upon the Menstrual Cycle

A Preliminary Report

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Certain areas of the nasal mucosa have been demonstrated to show physiological changes related to those of the endometrium during the menstrual cycle and pregnancy. The "genital spots" of the nasal mucosa and their changes (occasionally including vicarious menstruation) have been described by Fliess,[1] Roth,[2] Hofbauer and Hoerner,[3] Ash and Raum,[4] Henderson,[5] Israel[6] and others. The physiological correlation of the endometrium and of the nasal mucosa suggests that pharmacological agents administered systemically to produce decongestion of the nasal mucosa might also serve to decrease the vascular engorgement and congestion of the endometrium. By this means it might be possible to decrease the amount of blood lost at menstruation. If this could be done, it would be of real value in the treatment of patients with excessive menstruation. A patient directed my attention to the possibility of this treatment of menorrhagia when she observed a decreased menstrual flow at the time she was being given an oral nasal decongestant.

A study is being undertaken to determine to what extent the endometrial cycle, and especially the amount and duration of the menstrual flow, may be modified by an orally administered nasal decongestant. The menstrual abnormalities being given special study include menorrhagia, metrorrhagia, and endometriosis. The effect of an oral nasal decongestant upon cyclically recurring mastalgia is also included for evaluation. The discussion today is a preliminary report of the results which have been obtained to the present time.

Procedure

The patients in the study are all from private practice and have had organic diseases other than endometriosis ruled out before being selected for treatment. A detailed record of the patient's menstrual cycle is obtained before the medication is begun. The oral nasal decongestant which has been employed is in the form of a sustained release capsule (Ornade*) containing 8 mg. of chlorprophenpyridamine maleate, 50 mg. of phenylpropanolamine hydrochloride and 2.5 mg. of isopropamide iodide. The patient is advised to take one capsule every 12 hours as needed. She is requested to report upon her condition at six hours and at 12 hours after beginning her medication, and then to report every two days for as long as the medication is continued. Her report includes the amount and the duration of the menstrual period, a description of any changes which might be observed in the severity of the dysmenorrhea or mastalgia associated with the menses, together with any side effects which she has observed.

Results

The study was begun on April 23, 1961. Since that time 16 patients have been followed through a menstrual period during which each one received an oral nasal decongestant. A summary of the results in each patient is included under the indication for which the case was selected.

MENORRHAGIA. The most striking change in the menstrual pattern of the patients in the study was observed among those with functional menorrhagia (table 1). The menstrual flow decreased appreciably after the oral nasal decongestant was administered in seven of the eight patients in this category. The change in the amount of flow was observed to begin within four hours after the first capsule was taken. The rate of menstrual bleeding decreased after the medication to approximately one-third the amount present before the treatment. Although the amount of bleeding decreased, the length of the period was not shortened in most of the cases. The amount of medication employed by each patient is listed in table 1.

ENDOMETRIOSIS. The effect of the oral nasal decongestant upon five patients with endome-

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Read before the Florida Obstetric and Gynecologic Society, Miami Beach, May 28, 1961

*Smith Kline & French Laboratories.

Table 1.—The Control of Menorrhagia

Case Number	Age	Amount of Menses Before Treatment	Interval Before Effect of Treatment Seen	Response to Treatment Amount of Menses	Duration* of Menses	Number of Capsules Taken
1	44	18 pads/day	Began treatment before onset of menses	5 pads/day	5 days	10
2	37	20 pads in 2½ hrs.	3½ hrs.	3 pads/day	1½ days	3
3	41	5-6 pads/day	No change seen	5-6 pads/day	5 days	5
4	37	Menses for 7 days, now 12 pads in 12 hrs.	3 hrs.	4 pads/day	5 days	10
5	26	6 pads in 6 hrs. (P.M.P. 16 pads/day	4 hrs.	6 pads/day	7 days	1
6	21	15 days at 6 pads/day	3 hrs.	2 pads/day	7 days	12
7	20	7 days at 7 pads/day	4 hrs.	4 pads/day	1½ days	3
8	24	2 days at 8-9 pads/day	4 hrs.	3-4 pads/day	4 days	8

*Indicates the length of menses after treatment was begun.

Table 2.—The Effect upon Patients with Endometriosis

Case Number	Age	Usual Menstrual Period	Response to Treatment	Comment
9	29	6 days (with 10 pads/day during 2 days) Moderate pain	Bleeding half as much as usual	Pain mild
10	27	5 days with 4-5 pads/day. Moderate pain	Bleeding 25 per cent less than usual	Only slight pain. "I could walk standing up straight"
11	33	5 days with 6 pads/day. Moderate pain	Bleeding about same*	Pain was less*
12	37	6 days (with 10-12 pads/day during 2 days) Mild to moderate pain	Bleeding 75 per cent less than usual	No pain
13	42	6 days with 4 pads/day. Moderately severe pain	Bleeding 25 per cent less than usual	No pain. "It was the nicest period"

*Patient could not give more specific information.

triosis is summarized in table 2. A decreased menstrual flow was observed by four of the patients, but a significant change in the duration of the period was not noted. All of the patients secured what they considered satisfactory relief of pain. (It should be remembered that the change in bleeding and in pain has been followed through only one menstrual period so far.)

Other Conditions. One patient with functional metrorrhagia, case 14, was treated with the oral nasal decongestant. The patient estimated that the amount of the menstrual flow decreased 50 per cent, but the bleeding continued until endocrine therapy was also employed. The response of one patient, case 6, with menorrhagia as well as metrorrhagia is summarized in table 1.

Cyclically recurring mastalgia in two patients, cases 15 and 16, was treated with the oral nasal decongestant. Both patients stated that the discomfort was relieved while they were treated with the medication.

Side Effects. Drowsiness was reported to be the most frequent significant side effect and it was reported by approximately 20 per cent of the patients. In only one case was it severe enough to require the patient to discontinue her usual activities.

Discussion

The results obtained so far in the study of the effects of an oral nasal decongestant suggest that it may be possible by its use to produce a decrease in the amount of blood lost at menstruation. The

best response has been observed in patients with functional menorrhagia. It is not anticipated that changes in hormonal balance will be produced by the oral nasal decongestant. It is unlikely that metrorrhagia will be corrected by the medication of this study alone although it is possible that the amount of the blood loss may be decreased.

It seems possible that an oral nasal decongestant may decrease the amount of the menstrual bleeding by the implants of endometriosis. If this effect occurs, the treatment could provide some relief of the symptoms and perhaps slow the progression of the disease. It may be found that an oral nasal decongestant can produce some relief from the discomfort of cyclically recurring mastalgia.

It is planned as a part of this study to secure endometrial biopsies. An endometrial biopsy is to be obtained immediately before beginning treatment and is to be repeated at varying intervals after the treatment has begun. By this means it should be possible to determine if visible changes in the vascular engorgement and congestion of the endometrium are produced by the oral nasal decongestant.

One comment of caution is suggested by the material of this report. If the vascular engorgement, congestion and edema of the endometrium are decreased by an oral nasal decongestant, it seems unwise to employ this type of medication during pregnancy, especially during the early months of pregnancy. The decreased blood supply at the site of implantation could be detrimental to the developing embryo.

It should be emphasized that there is no expectation that oral nasal decongestants can serve as a satisfactory treatment for organic diseases of the pelvic genital organs, except perhaps for patients with endometriosis. Complete diagnostic studies, with therapy as indicated, are necessary for the proper management of menstrual irregularities.

Summary

The correlation of the changes of certain areas of the nasal mucosa to the physiological changes of the endometrium suggests that an oral nasal decongestant may produce a decrease in the vascular engorgement and congestion of the endometrium as well as in that of the nasal mucosa.

A preliminary report of the results of a study of this subject indicates that a favorable response can be obtained in patients with functional menorrhagia if they are given an oral nasal decongestant in adequate amounts.

Patients with pelvic endometriosis have been treated with the oral nasal decongestant. They have reported a decrease in the amount of the menstrual flow and satisfactory relief of pain.

Patients with functional metrorrhagia observed a decrease in the amount of bleeding when treated with an oral nasal decongestant. The bleeding may persist, even though in decreased amounts, until other therapy is instituted.

Cyclically recurring mastalgia has been reported to be relieved by the patients receiving the oral nasal decongestant.

The material of this report suggests that it may be unwise to administer an oral nasal decongestant to an obstetrical patient, especially during the early months of pregnancy, because of the possibility of decreasing the vascular engorgement of the decidua at the site of implantation.

ADDENDUM (Aug. 18, 1961).—The response described for the patients in this report has been maintained through three more menstrual cycles. Ten additional patients with functional menorrhagia have been treated with the oral nasal decongestant used in the study. The response has been good in nine, similar to that obtained in seven of the eight patients in the original report. The results were unsatisfactory in one patient, and dilation and curettage were required to control the bleeding.

Four additional patients with pelvic endometriosis have been treated with the oral nasal decongestant. All of these have experienced complete, or nearly complete, relief of pain.

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384 Peachtree Street, Northeast.

Diagnostic Clinic: Acute Diagnostic Problem

Case Summary

On Saturday, May 20, 1961, at 9:30 p.m., Mrs. L. telephoned, saying, "Oh Doctor, my mother, who lives with us, is in terrible pain. Won't you please come at once? Our regular medical doctor is out of the city. My husband and I realize that you do surgery, but we thought that since mother is in such terrible pain, the trouble might be in your line. Please come quickly."

Examination in the Home:

History.—The patient was a 75 year old white woman whose chief complaint was difficulty in breathing and abdominal pain.

Past History.—She underwent a general physical examination two years previously. She had been treated for high blood pressure.

Present Illness.—For the past 14 days she had belched a great deal and she stated that on Thursday morning (this was Saturday night) she spit up bile and then again that night she spit up more bile. She differentiated this from vomiting by saying it just came up without any effort. She volunteered the information that she had had indigestion for weeks, but had been eating heartily and not dieting in any way. At 9:30 Saturday night, 30 minutes prior to examination, she was at the dinner table when she experienced a sudden acute pain in the abdomen and she became so ill that she had to be picked up and carried to her bed. There had been no vomiting, but at the time of examination she was nauseated and felt that she would enjoy vomiting very much. Her chief complaint was a very heavy feeling in the chest, difficulty in breathing, and severe abdominal pain.

This case report presenting an acute diagnostic problem and the one following on a heart and lung disease provide the subjects of the two Diagnostic Clinics at the Association's Annual Meeting, May 10-13 in Miami Beach. The Clinics have been arranged by Dr. Franz H. Stewart of Miami. Dr. Scheffel H. Wright of Miami will serve as moderator for the discussion of the acute diagnostic problem. Participating will be Drs. Fredie P. Gargano and Chester Cassell of Miami, Dr. David R. Murphey Jr. of Tampa, and Dr. John R. Emlet of Pensacola. Dr. William M. Straight of Miami will serve as moderator at the second Clinic. Participating in the discussion will be Dr. Manuel Viamonte Jr. of Miami, Dr. John M. Packard of Pensacola, Dr. David M. Travis of Gainesville, and Dr. James E. Cousar III of Jacksonville.

Examination.—Examination showed a well developed, well nourished white woman, who gave her age as 75. She was lying in bed in evident discomfort. She was pale. The temperature was 97 F. The pulse rate was 100 and the blood pressure 140/100 mm. Hg. Determination of cardiac sounds was difficult owing to the very loud breath sounds which were heard over both sides of the chest and over most of the abdomen. The breath sounds over the left side of the chest in particular were indistinguishable from the same sounds heard when the stethoscope was put over any part of the abdomen. Percussion of the right side of the chest was normal

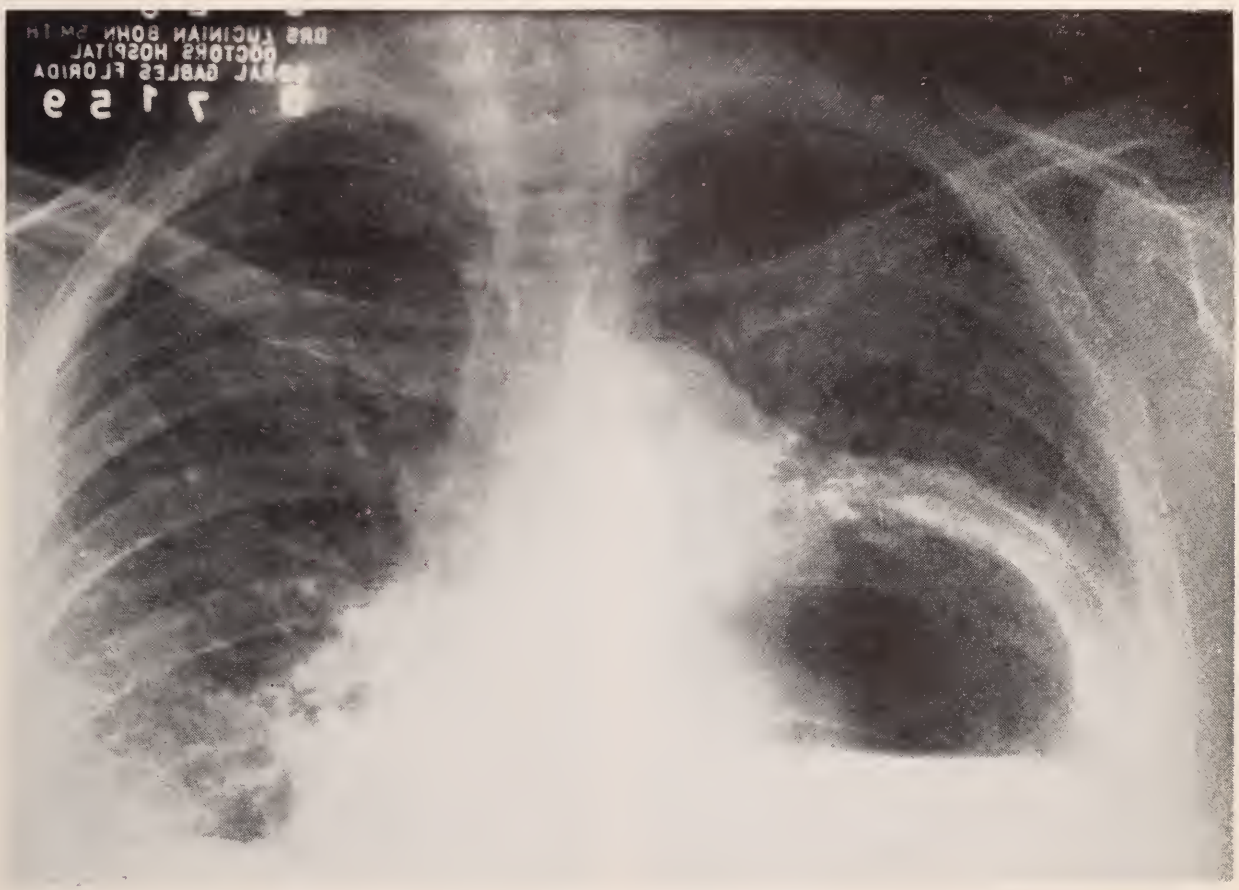


Figure 1



Figure 2



Figure 4



Figure 3



Figure 5

whereas percussion of the left side showed a tympanitic note extending high up toward the clavicle.

The abdomen was moderately distended. Palpation elicited tenderness throughout, with acute tenderness over the epigastric region, so acute that the slightest pressure caused the patient to cry out. No peristaltic sounds were audible, but as mentioned, loud breath sounds were heard over most of the abdomen indistinguishable from those heard over the left side of the chest. The percussion note over the abdomen was tympanitic. No further examination was made as it was evident that the patient was in mild shock and that an acute surgical catastrophe had occurred. She was placed in an ambulance and taken to the hospital.

Hospitalization:

Laboratory work at the hospital showed the urine to be normal with the specific gravity 1.021. On examination of the blood, the hemoglobin estimation was 15 Gm. (94); the hematocrit reading was 45.5; the white blood cell count was 6,900 with segmented forms 30, stab forms 28, juveniles 5, lymphocytes 34, monocytes 2, and eosinophils 1.

She was taken to the x-ray department where a flat film of the abdomen and an upright film of the chest and abdomen were made. (figs. 1 and 2).

A Levin tube was inserted, but it did not seem to go down properly or the normal distance. Another film of the chest was now made. (fig. 3).

Needing additional diagnostic help, the surgeon asked the roentgenologist to confer with him. It was now about 11:30 p.m. Gastrografin was administered. See figures 4-6.

The patient was now taken to the operating room.

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Miami



Figure 6

Diagnostic Clinic: Heart and Lung Disease

Case of Cardiopulmonary Disease

This case concerns a 20 year old man who was first seen at the Jackson Memorial Hospital on Feb. 28, 1961, and who was subsequently readmitted in September, October and November 1961, expiring on Nov. 17, 1961. An autopsy was obtained.

He was born in South Carolina. His father had severe rheumatic heart disease and one bout of subacute bacterial endocarditis; his mother died of a uterine carcinoma; and his four sisters were always healthy.

At the age of two months during the first of many bouts of "severe chest colds" that the patient was to suffer, he was found to have a heart murmur, and his parents were told he probably had congenital heart disease. No further investigation was advised or carried out. At about the age of six there began a twisting and bending of the patient's spine which progressed over a two year period, then stabilized, leaving him with a marked kyphoscoliosis; this was ascribed to poliomyelitis; he received no specific therapy. During childhood exertional dyspnea and his twisted spine made him unable to keep up with the other children. He recalled no chest pain, paroxysmal nocturnal dyspnea, ankle edema or cyanosis. He could not recall symptoms suggestive of rheumatic fever, growing pains, scarlet fever, or any other severe illness except frequent respiratory infections as mentioned. One month prior to his first admission to Jackson Memorial Hospital, a low grade fever, malaise, a nonproductive cough, increased exertional dyspnea and occasional nocturnal dyspnea developed, and for the first time cyanosis of the lips and nailbeds. His South Carolina physician started him on digitoxin (0.15 mg/da) and hydrochlorothiazide (50 mg/da) and sent him to Miami for hospitalization and evaluation.

On arrival, he was noted to be a very deformed, small, thin, white male who was alert though dyspneic and cyanotic at rest. The temperature was 99.4 F., pulse rate 140, respirations 38, and blood pressure 115/85 mm. Hg. The significant physical findings were: a deformity of the right external ear; a severe rotatory kyphoscoliosis of the cervicodorsolumbar spine; occasional fine moist rales at both lung bases; a definitely enlarged and displaced heart with the point of maximal impulse in the left fourth intercostal space and the midclavicular line; a marked systolic thrill at the left third intercostal space parasternally; a grade V harsh, holosystolic murmur loudest along the lower left sternal border and transmitted toward the left axilla but not to the neck; P-2 was greater than A-2 and exhibited fixed splitting; the rhythm was regular but an occasional third heart sound was audible at the apex; the abdomen showed no palpable organs, masses or tenderness; there were good pulses in the extremities and the previously noted cyanosis, but no edema or clubbing.

Laboratory studies during his first hospital stay (February 28 to March 29) showed a normal complete blood count (hemoglobin estimation 15 Gm. hematocrit reading 56), reticulocyte count, urinalysis, fasting blood sugar, blood urea nitrogen, four blood cultures, purified protein derivative test, and stool for ova, parasites, and occult blood. The initial blood carbon dioxide combining power was 40.8 mEq. (normal 22-31 mEq.); this dropped to 36.9 mEq. after one week. The initial serum chloride

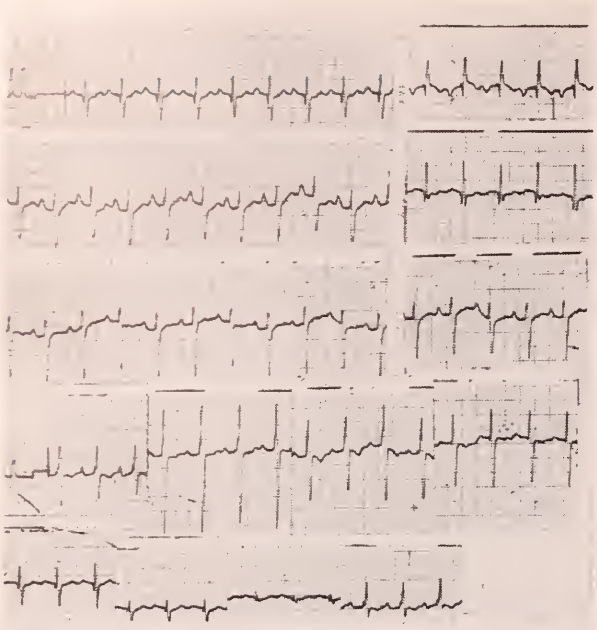


Fig. 1.—Electrocardiogram of Feb. 28, 1961. (Note: ½ standardization in the chest leads)



Fig. 2.—Right lateral chest x-ray, March 1, 1961.

was 83 mEq. (normal 94-110); this rose to 85.5 mEq. after one week. Electrocardiograms showed a sinus tachycardia of 100 with a first degree heart block (PR 0.22 sec.) and changes consistent with right atrial and right ventricular hypertrophy (fig. 1). A phonocardiogram showed a diamond-shaped systolic murmur loudest at the pulmonic area. Vectorcardiograms showed clockwise rotation in the horizontal plane and counterclockwise rotation in the frontal plane. It was thought consistent with combined ventricular and right atrial hypertrophy. Chest x-ray and cardiac fluoroscopy were difficult to interpret because of the gross deformity of the chest and displacement of its contents (figs. 2 and 3). He was twice evaluated by the pulmonary laboratory, obtaining the following values:

	March 16		March 21	
Ventilation	Observed	% Predicted	Observed	% Predicted
Maximum breathing capacity	17 L/min	15%	27 L/min	25%
Vital capacity	526 cc	13%	647 cc	16%
Arterial Blood	Room Air	100% Oxygen	Room Air	100% Oxygen
Oxygen content, vol%	8.0	19.2	15.7	20.6
Oxygen capacity, vol%	20.7	20.7	20.8	20.8
Oxygen saturation, %	39	93	77	99
CO_2 content, vol% (WB)	88	88.5	74	75
CO_2 content, vol% (S)	104	106	89	91
CO_2 tension, mm Hg	84	100	69	78
pH	7.35	7.27	7.36	7.31

These data were thought consistent with severe pulmonary hypertension without evidence of right heart failure or right heart valvular disorder. It was thought that the response to oxygen breathing and the Cardio-Green dilution curves failed to show a significant intracardiac right to left shunt, but the Cardio-Green curves together with the nitrous oxide inhalation study were consistent with a left to right shunt. The oxygen studies were interpreted as inconsistent with a shunt at the atrial level. It was not possible to get satisfactory pulmonary capillary pressure tracings.

These studies were interpreted as compatible with a severe ventilation-perfusion imbalance such as seen in early atelectasis or a right to left intracardiac shunt.

After he had improved somewhat, on March 28 a cardiac catheterization was carried out, obtaining the following data:

Position	Content	Capacity	Saturation	CO_2	Pressure S/D	M
RV	13.5				71/5	
PA (rest)	10.9				76/36	52
PA (rest)	12.4	18.6	67%	70.4	120/78	93
PA	11.6					
PC	NSO					
RV	12.6					
RA	10.4					2
SVC	11.7					
FA (OR)	17.8	18.7	96%	70.8		

Pate 96/min
O_2 Conc . . . . 233 cc/min
N_2O study — PA/FA = 51%

On sodium restriction, continuation of the digitoxin, chlorothiazide, broad spectrum antibiotics and intermittent positive pressure breathing treatments, the patient improved so that he no longer required oxygen. A cardiac surgical consultant thought surgery was not indicated. He was discharged on digitoxin 0.15 mg/da, chlorothiazide



Fig. 3.—Chest x-ray, anteroposterior view, March 1, 1961.

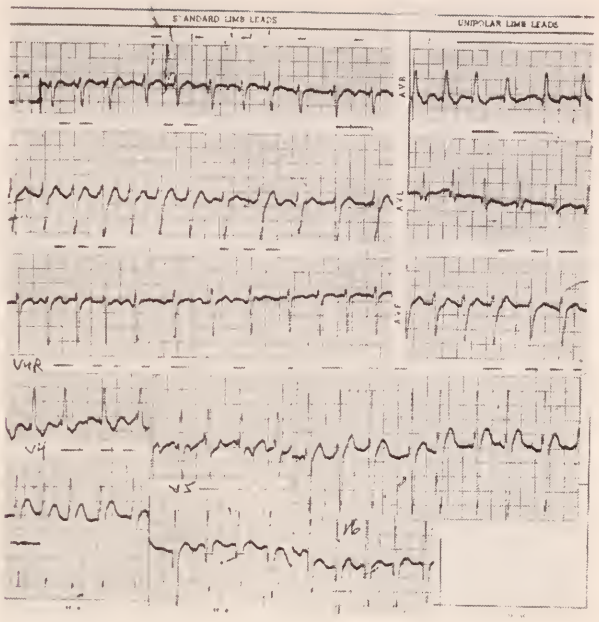


Fig. 4.—Electrocardiogram of Nov. 10, 1961.

500 mg/da, supplementary potassium chloride, Quadrinal four times a day, and intermittent courses of tetracycline. On this regimen he did fairly well until September when, because of increasing dyspnea and cyanosis, he was readmitted to Jackson Memorial Hospital (September 22 to 29). The results of the physical examination differed little from the findings of the previous admission. The temperature was 99.6 F., the pulse rate 140, respirations 20, and blood pressure 90/66 mm. Hg. Mention is made of a markedly accentuated P-2 and a short mid-diastolic murmur audible along the lower left sternal border. The hemoglobin estimation was 14.4 Gm. with a hematocrit reading of 54.5; the carbon dioxide combining power was 28 mEq. and chloride 87 mEq. All other laboratory values including electrocardiograms and chest x-rays were essentially the same as on the previous admission. The PR interval was not prolonged this time. Pulmonary function studies on September 27 gave the following values:

Ventilation	Observed	% Predicted
Maximum breathing capacity	29 L/min	26
Maximum breathing capacity	After Isuprel	No improvement
Vital capacity	526 cc	13
Timed vital capacities		
1 sec., % of total	67%	(more than 75%)
2 sec., % of total	81%	(more than 85%)
3 sec., % of total	88%	(more than 95%)

Arterial Blood	Room Air	100% Oxygen
Oxygen content, vol%	11.2	20.2
Oxygen capacity, vol%	21.3	21.3
Oxygen saturation, %	53	96.1
CO_2 content, vol% (WB)	74.8	77.1
CO_2 content, vol% (S)	90.2	94.0
CO_2 tension, mm. Hg	70	76
pH	7.4	7.36

These data were thought essentially unchanged from the previous studies, and again indicative of pulmonary atelectasis or a right to left intracardiac shunt. They were also thought indicative of a long-standing carbon dioxide retention and a lack of reversibility of the obstructive airway defect.

Again rest, sodium restriction, digitalis, iodides and tetracycline restored the patient to his previous state of compensation. During this admission digoxin (0.5 mg/da) was substituted for the digitoxin. He was discharged on this regimen plus intermittent positive pressure breathing treatments three times weekly.

In slightly less than one month he was admitted to Jackson Memorial Hospital for the third time (October 25 to 31) and again for increasing dyspnea. This time he was described as in acute respiratory distress; temperature 99.2. F.; pulse rate 104; respirations 38; blood pressure 130/90 mm. Hg; the lungs showed moist rales at both bases; the point of maximal impulse was located in the sixth intercostal space at the anterior axillary line; and a 4 fingerbreadths tender hepatomegaly was noted. The hemoglobin estimation was 14.4 Gm. and the hematocrit reading 56.5. The electrocardiogram showed atrial tachycardia with block. The urine showed a pyuria which cleared on tetracycline therapy. Digitalis was pushed to tolerance and this with diuretics and supportive therapy resulted in prompt improvement. Again he was discharged on essentially the same regimen.

Eleven days later he was admitted to Jackson Memorial Hospital for the fourth and final time (November 10 to 17). Despite faithful adherence to the medical regimen and diet while at home, he had again become progressively dyspneic, and ankle edema had for the first time developed. There was no history of symptoms of upper respiratory infection, anorexia, nausea, vomiting or diarrhea.

Physical examination showed temperature 99.6 F; pulse rate 130; respirations 28; blood pressure 150/90 mm. Hg; acute respiratory distress; bilateral, basilar, inspiratory rales in the lungs; P-2 was "much greater than A-2;" a grade III pulmonic systolic murmur radiating to the neck was present in addition to the previously described murmur; a gallop rhythm was intermittently present; there was a tender, 4 fingerbreadths hepatomegaly with a questionable hepatojugular reflex; 3 plus bilateral edema of the legs to the knees and slight cyanosis of the nail beds. On this admission, the hemoglobin estimation was 14.9 Gm. with a hematocrit reading of 49. There was a leu-

leukocytes of 12,500 with 88 per cent polymorphonuclears. The blood urea nitrogen was 38 mg. per hundred milliliters, the carbon dioxide combining power 36 mEq. and the chlorides 77 mEq. An electrocardiogram showed more marked evidence of right atrial and right ventricular hypertrophy, and an atrial tachycardia with varying block which was interpreted as suggestive of digitalis toxicity (fig. 4).

The patient was given oxygen cautiously because of the previously elevated carbon dioxide combining power, but it soon became evident that he could not survive without continuous oxygen. Daranide and Diamox, carbonic anhydrase inhibitors, were tried without benefit. Digitalis was withheld in view of the electrocardiographic evidence of toxicity throughout this admission, but the atrial tachycardia with block persisted. Attempts to move the edema fluid with Mercuhydrin were unsuccessful probably because of the low serum chlorides. L-lysine monohydrochloride was given to increase the serum chlorides, but this did not help. He became progressively more dyspneic, unable to sleep and acutely anxious. About 5 p.m. on November 17 he suddenly became apneic, and resuscitation efforts were useless.

WILLIAM M. STRAIGHT, M.D.
MIAMI

From This Niche

An Unconscious Patient

Remember This Man

Today was different. Usually he could turn out a magazine article quickly and with little conscious effort. Writing was fun. But on this day things were different. Ideas would come, and yet sentences and paragraphs would not form.

Perhaps he was just tired. He had recovered well from the hepatitis and the resultant cirrhosis. There had been no more evidence of bleeding since the portocaval shunt several years ago. He had been living a fairly normal life. The cataracts and glaucoma were both a big nuisance, but seemed pretty well under control now. His diabetes was very mild and had been rather perfectly controlled for many months by only moderate restriction of the carbohydrates in his diet.

Backache from his old skiing injury was causing pain, but in the last day or two, Soma Compound with Codeine was controlling this pain. Maybe this medication was interfering with his writing. He was taking one to three a day.

His symptoms became worse. He became increasingly drowsy. His wife found difficulty waking him even to feed him. After a day or two he could not get out of bed, and just slept all the time. He could be aroused to mumble, but that was all. He fell out of bed once or twice and was incontinent. When examined, he could not be aroused. He could turn or twist in bed and seemed to use all four extremities without difficulty. The neck was not stiff. Blood pressure was 120/80 mm. Hg., respirations 22, pulse rate 118 and temperature normal.

He was transferred to the hospital; his eye drops and Diamox which he was using for his glaucoma were not used in the hospital. He became quite manic and difficult to manage so that sedation and restraints were required.

The various examinations including the spinal puncture were all normal except for the electrolyte pattern. The carbon dioxide combining power was found to be 14 mEq. The potassium was 3.8 mEq. The other findings were all within normal limits; serum chloride was 120 mEq., serum sodium 140 mEq., blood urea nitrogen 16 mg. and blood sugar 133 mg. per hundred milliliters, and serum ammonia 0.25 mg.

He was given intravenous 1/6 molar sodium lactate, glucose, water, and saline. By the next day the carbon dioxide combining power was up to 18 mEq.

Two days later he was still confused, but was able to sit in a chair and began to eat and drink for himself. By this time the carbon dioxide combining power was 25 mEq.

He became perfectly well with only one complication and that was urinary infection from the indwelling catheter. Since discharge from the hospital, he has remained quite well.

Carbonic anhydrase inhibitors may be of great benefit for glaucoma and a safe medication, but this man would be hard to convince. If the patient is obtunded, semicomatose or confused, or if acetazolamide is being used—remember this man.

FRANZ H. STEWART, M.D.

President's Page

Conclusion(s)

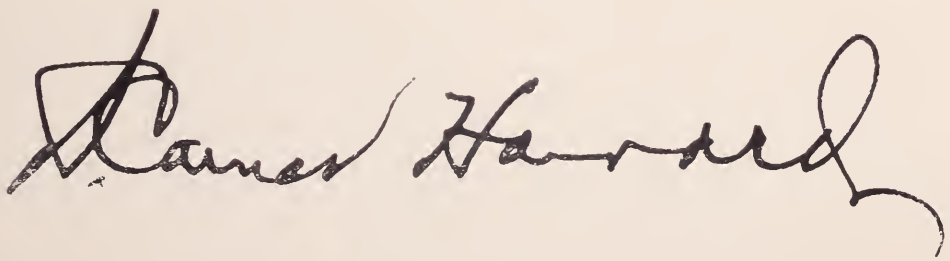
Another year has slipped past, and I find that it is now time for me to write my last President's page. This year, as you all are aware, has been quite eventful. On the national level we have been constantly threatened with the passage of the King-Anderson bill, which we do not need or want, with the subsequent repeal of the Kerr-Mills bill, which we want and which is needed. The Florida Medical Association has been well in the vanguard in the fight against Socialized Medicine. You can well be proud of the work it has done along this line. Many of the ideas which are being used today in this fight were conceived by men in the Florida Medical Association.

On the state level all has not been serene either. Problems have come up from time to time which I am glad to say have for the most part been solved. The Fee Schedule Committee has been probably the busiest one in the state. I realize that all the problems of this Committee are not completely solved as yet, but I have the utmost confidence in the integrity, fairness and honesty of all the members of this Committee. What is humanly possible to be done, I am sure they will do. All of us must have patience and be willing to understand and to help. Their problem is not a simple one. This is something which cannot be done by one individual or a small group. We have to stay together and present a solid front as one organization to solve the Fee Schedule problem. This Committee is and has been working for the common good of the Florida Medical Association and not for any one group. By the same token it has not tried to discriminate against any one group. We must all stand together and solve this problem in a democratic way.

In a few days we will be in the midst of our Annual Meeting. This, to me, is the most important event of the year as far as Florida Medicine is concerned.

The House of Delegates holds the limelight and rightly so as it is the law-making body of our democratic organization. Each man in the House is elected by his fellow society members to represent them. This, then, is not only an honor but also a duty and a privilege. It is in this body that the power to make the laws and rules by which we are governed lies. We are a democratic organization and in the House of Delegates is where our voice is heard. There is no reason why any individuals or groups cannot express themselves in the House of Delegates following rules of procedure which have already been established.

I would like to express my thanks to all of you for your cooperation during the past year. As your President, I have had your loyal support and in many instances splendid advice which has made my job easier. My successor is an able man and I am sure will lead us in the right direction. I hope we will all join in and give him our wholehearted support, which he so richly deserves.





Another Viewpoint: Senate Hearing on Problems of the Aged

I attended the Senate Subcommittee hearing in Fort Lauderdale on February 15, 1962 and having read the newspaper reporting, felt that another viewpoint might be worth while. In a highly charged atmosphere at the War Memorial Auditorium before an estimated audience of 3,000, I heard the charges, countercharges and boos.

The morning session was conducted by Senator George Smathers (D-Fla.) with decorum and dignity, which, however, at the afternoon meeting nearly got out of control. It was obvious that Senator Jennings Randolph (D.-W.Va.) and Senator Oren Long (D-Hawaii) favored King-Anderson type legislation and more. Senator Smathers was apparently honestly trying to find an answer to the problem of medical care for the aged. On the basis of my observations, it would seem that the committee could only recognize that the hearing was packed by a vocal, massive majority of organized "senior citizens" club members, emotionally involved in a serious problem. One layman expressed it well when he said, "Senators, I hope you realize that the people who are opposed to this bill are not here, but working and paying their taxes."

The opponents presented their reasons for opposition to legislation of this type in a dignified, rational and decorous manner, despite boos, catcalls and threats often drowning them out.

Ex-Senator Claude Pepper brilliantly presented the viewpoints of the senior citizens to a standing ovation from the audience. He scored well with his recommendation of putting nursing and hospital care under Social Security and "letting the medical association find a way to pay the doctor." His charge that he wanted to do away with "socialized medicine" as practiced in the county-owned hospital by doctors who "experimented" upon patients was well received.

"Mr. A.M.A.," Dr. Ed Annis, countered in his usual efficient and effective manner that all who are old are not sick—or needy. He also stated that existing federal, state, local and private programs, with voluntary health insurance, constituted a sound economical means of meeting existing needs. He emphasized that Social Security would be bankrupted if used to provide an entirely different system of medical care.

Dr. Russell B. Carson presented the proposals of Blue Cross and Blue Shield in a calm and dispassionate manner, as an alternative to the proposed legislation.

Mr. Shreve, the 80 year old, retired, vigorous and credible president of the Fort Lauderdale Rotary Club and Past President of the United Fund, pled that arbitrary retirement at 65 was wrong in principle and constituted a waste of knowledgeable manpower when the country needs its best. He also stated that many of those his age neither wanted nor needed medical care—they could provide their own.

Mr. Phillips of the Fort Lauderdale Chamber of Commerce expressed his organization's disapproval of the pending legislation. Dr. Simon Doff reported upon the activities of the Florida State Board of Health in the field of the care of the aged. Of course, all of these opponents were booed despite the chairman's attempt to preserve order.

An interesting highlight by one of the proponents occurred when he stated that it was strange to him that in 1959, an election year, Senator McNamara held hearings on the problems of the aged in Florida. Again, in 1961, another election year, they were again having hearings. To which all of the members of the most exclusive club in the world promptly responded with stinging rebukes.

The opposition was well represented by speakers for the Four Freedoms and other organizations of senior citizens, as well as a preponderance of speakers at the "Town Hall" session which con-

cluded the meeting. It was at this session, where Dr. W. D. Wells, President of Broward County Medical Association, the President of Broward County Dental Society, the writer as President of the Florida Society of Internal Medicine and Dr. Miles Bielek, were booed down.

My conclusion after this experience is that a large and vocal organized minority is attempting to force this legislation through the Congress of the United States with the aid and assistance of our executive branch of government. It is politically expedient and as such will garner many votes in the Congress.

We should each assume our individual responsibility by working among our friends and patients to enlighten them on the significance of this legislation. Support our Florida Medical Committee for Better Government and the American Medical Political Action Committee. We should actively support candidates who are opposed to it—if we can find them.

Scheffel H. Wright, M.D.
Miami

Pregnancy, the Menstrual Cycle and the Nose

Ovarian endocrinology and the nasal mucosa have been the subject of several recent articles in The Journal. The discussions emphasized that small vessels the size of the coiled arteries of endometrium and those of Auerbach's plexus in the nose seem to be under the same hormonal control as witnessed by (1) control of the menstrual flow by the use of nasal decongestants and (2) hyperemia of the nasal vessels during pregnancy and the widely discussed vicarious menstruation.

These facts at first seem to represent a divergence of opinion, but the direction of investigation has come from two different specialties, and they arrive at very similar conclusions.

It is important to beware of treating one body system without being aware of the potential effects the medication may have on a seemingly unrelated and perhaps distant organ. Dr. John R. McCain, in his paper entitled "The Effect of an Oral Nasal Decongestant Upon the Menstrual Cycle," warned that nasal decongestants used during an early pregnancy may tend to decrease the blood flow to the decidua, hinder maturation of the newly forming placenta and, therefore, increase the chances of disruption of the pregnancy. Similarly, the allergens present in Florida may be more aggravating in pregnancy because of the increased congestion of the nasal mucosa. We should remain aware, however, of the potential hazards of the usual treatments.

James R. Sory, M.D.
West Palm Beach

Fee Schedules

Time and time again the remark is made that the specialist should get a higher fee on a fee schedule basis than a nonspecialist. This position might seem reasonable on the face of it since one might say that because of superior training, longer training, and limitation of practice, one man deserves a higher fee than another for the same procedure. I have thought much about it because it comes up so often. The more I have looked into it, the more obvious it is that it is not as cut and dried as it seems. There is much selfishness as well as much reasonableness mixed up in this concept of dual fee schedules for the specialist and the nonspecialist. Actually, what it begins to boil down to is qualifications and quality.

How do we define qualifications? If you really believe that medicine is benefited by having a dual fee system, then what you mean is that the specialist is better qualified and should be paid accordingly on the fee schedule. The more you get into it, the more you realize that aside from pure economic selfishness and the desire to dominate economically, what we are talking about is quality of medical care.

How do you define a specialist?

How do you define qualifications?

How do you define quality in medical care?

There are tremendous variations in these terms. In medical practice as we know it, rural, suburban and urban, there are all degrees of qualifications. We know that no one segment of medical practice does anywhere near all the work done in that speciality. The radiologists tell me that about 35 per cent of radiology is done by them. Now these are facts. Yet, if we attempt to say who is a specialist, we must define the term. How is it done? By the various boards? By the

various specialty societies? Is a thoracic surgeon to be in a different category from a general surgeon, both board-qualified or both members of the American College of Surgeons? Or a proctologist? Or a vascular surgeon? Is similarly a cardiologist in a different category economically from a general internist, both being board-certified and members of specialty societies? Or a pediatric urologist? Or a cancer specialist? Does this variation mean that we must end with infinite degrees of graduated fees paid different men for the same service? Obviously, this gets into the ridiculous, but you will find that if you talk seriously about it, there are trends toward just this situation.

The matter then gets into the field of qualifications rather than the specialty itself. Who should do alcohol injection of the trigeminal nerve? The anesthesiologists or the neurosurgeons or the neurologists or many other groups? Any man among them can be qualified, but who is to say? A man may be a qualified specialist today, but a year later by dint of no reading or study may not be quite as qualified; or by dint of alcohol or drug addiction may not; or by illness or injury. Is he then to lose his qualifications? And who is to take them? There is a trend for some of the medical school physicians to say that one should repeat his board examinations every three or four years. What would this requirement do to the control of specialization? Often there is a tendency, as now in our own state society in Workmen's Compensation problems, to try to get government (here in our state) to define who is a specialist by making a differential fee schedule. If you are a specialist, you then must be listed with governmental authorities ultimately as such to get the fee you demand. Does this not throw some of the control into the wrong hands where political manipulation is a great temptation?

Actually, it seems to me what we should be talking about is the quality of medical care. Here the qualified specialist with a heart and many extra qualities which make any good doctor, such as compassion, charity and kindness, is in a preferential position, but not too many will qualify for this category. This would be a mighty select society. If a man is the fanciest specialist in the world, but will not go when called or is not available when needed, then his quality of care is not as good as that of the country doctor who does go and does his best. Simply because a man has the qualifications and has paper proof of them does not automatically guarantee that he is the best man at any one time. He probably is, but he must prove it. The boards say time and again that they do not want to be made the butt of the ambitions of those who want to control economically the segments of practice covered by the boards.

From what I say, you might get the idea I am rabidly against a duality of charges. Not necessarily. I have my boards, but I am sure that using a fee schedule to try to make such differences will not work. The California Medical Society people have felt the same way. Here is the way I feel.

It is not to the good of organized medicine or to the public good to have duality of fees on fee schedules. It is unworkable and can only lead to jealously, dishonesty, and unhappiness. The motives back of such a plan are questionable. I doubt if the majority of members of any specialty group really understands this that they would be in favor of it. If, however, we ever did have a duality, a list of people qualified would have to be developed for each local society and be revised monthly practically. If all of organized medicine were satisfied with this arrangement, then it would work, but only under almost dictatorial control of the medical society; otherwise, controversy and the control would pass to government or the medical schools.

The best method, of course, is not to have a dual fee schedule, but rather there should be a greater differential in payment between the difficult and delicate procedure, done usually only by the highly trained men, and the less difficult more common one. This may be done through Relative Value Studies.

But as it is, remember that the highly trained qualified specialist now is in a preferential position which puts him into a much better position economically, and "medically."

In Florida there is no specialty which does more than 50 per cent of the work covered in that field. Not all radiology is done by radiologists, not all skin diseases are treated by dermatologists, not all neurosurgery is done by neurosurgeons. Even at that, however, each specialty is doing more and more as its doctors show their capabilities, and with the support of the other doctors generally.

These are their preferential positions: They are acknowledged leaders in their respective fields in the community; as such they get many patients because of this position. They are therefore in a better competitive position. They general-

ly control the policies in many ways in their medical world concerning their specialties, aside from economics. They are section or department heads; they have program preference in their subjects; they are recognized as consultants; they have broader hospital privileges and positions; generally they control in many ways their segment of practice.

Now if the qualified specialists do not become smug, conceited, or snobbish in a medical way and stay reasonable, their strength and leadership will increase, and eventually if it is for the best public good, they may gain an even stronger position, but they have not proved themselves worthy of it yet.

Henry J. Babers Jr., M.D.
Gainesville

Current Practices in Correction of Errors of Refraction

The papers on "Problems Encountered During Fitting and Wearing of Contact Lenses" by Dr. Frederick E. Hasty Sr. and "Safety Lens Materials" by Dr. Thomas G. Dickinson in the current issue of The Journal should be interesting to all physicians.

Contact lenses have been used with varying degrees of success for three quarters of a century. For 30 or 40 years the lenses were blown from glass. Popularity of contact lenses had its beginning with the introduction of plastic lenses about 25 years ago. Really widespread use of contact lenses began about 12 years ago with the introduction of small plastic corneal lenses. Now several million people have been fitted with contact lenses with highly variable results. Many people wear the lenses with comfort all day long, while undoubtedly millions of lenses have been worn for a time and then cast aside in dresser drawers. There is as yet no successful bifocal contact lens. The prime indications for use of contact lenses at the present time are for correction of errors of refraction in conical cornea, following cataract surgery, irregular astigmatism due to corneal scarring and for cosmetic purposes. That vanity must be considered is shown by the fact that a high percentage of all contact lenses now being fitted are for myopia in women. These people will obtain contact lenses and often without knowledge of possible dangers. Such lenses when properly fitted and used are fairly safe and a source of great happiness to the patient. When improperly fitted and used, they are a potential source of grave danger to the eyes. They are basically a foreign substance in contact with a sensitive organ which was not designed to tolerate a foreign body. Corneal ulcers have developed, and eyes have been lost from wearing these lenses. With the patient having so much at stake, the fitting and wearing of contact lenses should be done by an ophthalmologist or under the close supervision of an ophthalmologist.

Safety lenses, as Dr. Dickinson pointed out, are hardened glass or plastic. The glass variety has to be thicker and heavier than ordinary crown glass lenses. Plastic lenses are light, but become scratched more easily than glass. This is true even with the newer allyl resin lenses. All safety lenses are more expensive than glass. These reasons probably account for the fact that most lenses now being fitted are of ordinary crown glass. It follows that most lenses in use today are a potential source of eye injury from glass breakage. This condition we should try to change. If a harder plastic lens is developed, which will not readily become scratched, we should be able to eliminate the danger rapidly.

Marion W. Hester, M.D.
Lakeland

Clinical Comment



Seminar in Obstetrics and Gynecology

The format of the Seminar in Obstetrics and Gynecology presented at the University of Florida College of Medicine in Gainesville on January 11 and 12, 1962, consisted of formal lectures in the morning and round-table discussion in the afternoon. The guest speakers were Dr. Duncan E. Reid, Professor and Chairman, Department of Obstetrics and Gynecology, Harvard Medical School, Boston, and Dr. Howard C. Taylor Jr.,

Professor and Chairman, Department of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York.

Subjects presented by Dr. Reid were "Rupture of the Uterus," "Current Obstetric Controversies," "Shock in Obstetrics," and "The Prevention of Immediate and Remote Adverse Effects on the Fetus." In the presentation "Rupture of the Uterus," Dr. Reid emphasized that the critical factor in American obstetrics today is rupture of the uterus secondary to a previous cesarean section. Other causes such as spontaneous rupture and rupture secondary to traumatic delivery are definitely on the decrease. In his talk entitled "Current Obstetric Controversies," Dr. Reid discussed many of the medical complications of pregnancy. Of chief interest were his comments concerning heart disease in which it was his belief that therapeutic abortion is rarely indicated and that cardiac surgery during pregnancy is not advisable.

In the presentation entitled "Shock in Obstetrics," Dr. Reid stressed the fact that shock in obstetrics is similar to shock experienced by nonpregnant persons. He stated that it is one of the leading causes of maternal death in the United States at the present time and that if one were concerned with preventability, approximately 50 per cent of the cases would be preventable. In his last presentation entitled "The Prevention of Immediate and Remote Adverse Effects on the Fetus," Dr. Reid stated that this is an area of utmost concern to all who deliver babies, but one in which little is known at the present time. He thought that one area in which improvement is needed is in the reduction of traumatic delivery.

Presentations by Dr. Taylor were "Pelvic Pain Syndrome," "Endocrine Therapy in Gynecology and Obstetrics," "Diagnosis and Treatment of Ovarian Carcinoma," and "Management of Fibroids of the Uterus." In his first presentation Dr. Taylor reviewed the history, difficulties in diagnosis, and extreme difficulty in management of the patient with pelvic pain syndrome. He emphasized that the number of patients with this syndrome requiring abdominal surgery is extremely small. In his next presentation on "Endocrine Therapy" he stressed the need for more critical evaluation of the various hormonal preparations being employed today. He reviewed the acceptable indications for the use of estrogen, progesterone, and androgen therapy and suggested that there is little, if any, real indication for using the many combination drugs that are on the market today.

In discussing the next subject, "Diagnosis and Treatment of Ovarian Carcinoma," Dr. Taylor emphasized the importance of careful evaluation of any ovarian enlargement because of the poor prognosis in ovarian neoplasm and the importance of early diagnosis. The primary therapy still remains total abdominal hysterectomy, bilateral salpingo-oophorectomy, and omentectomy. In presenting his final topic, "Management of Fibroids of the Uterus," he discussed the indications for the removal of the uterus and emphasized the need for determining changes in size, presence of real symptoms, and evaluation of vaginal bleeding. He thought that in women with infertility and fibroids, myomectomy might be considered, provided all other factors had been excluded.

VINCENT G. STENGER, M.D.
GAINESVILLE

Association News

Summary of Board of Governors Meeting Held April 5, 1962

Annual Reports.—Received and transmitted to the House of Delegates all annual Council reports and resolutions received to date. Supplemental reports and additional resolutions will be included in the Delegates' packets.

Nominations Blue Shield Board of Directors.—Selected the following two candidates from the three names submitted by the Nominating Committee for the Blue Shield Board of Directors, to be voted upon in May:

Medical District "A"
Three year term
Henry J. Babers Jr., M.D.
Henry L. Harrell, M.D.

Medical District "C"
Three year term
W. Dean Steward, M.D.
David J. Lehman Jr., M.D.

Medical District "D"
Three year term
John D. Milton, M.D.
Donald F. Marion, M.D.

At Large
Three year term
Thomas E. McKell, M.D.
Alpheus T. Kennedy, M.D.

Certified nominations of the following lay members of the Board:

Medical District "C"
Three year term
Mr. C. DeWitt Miller

At Large
Three year term
Mr. James H. Couey Jr.

At Large
Two year term
Mr. H. P. Osborne Jr.

Home Nursing Care.—Adopted a resolution urging full cooperation of county medical societies with health departments and voluntary visiting nurse associations in the evolution of comprehensive home care programs.

Assistant Editor — The Journal.—Appointed John M. Packard, M.D., as an assistant editor of The Journal of the Florida Medical Association.

Florida Neurosurgical Society.—Withdrew recognition of the Florida Neurosurgical Society as a specialty society in the Florida Medical Association, effective immediately.

Florida Orthopedic Society.—Accepted the action of the Florida Orthopedic Society as complying with the action of the Board of Governors taken on January 13, provided that the Orthopedic Society distribute its action to all those to whom the original Orthopedic Society resolution was sent.

Disciplinary Action.—Adopted the recommendations of the Judicial Council and expelled three members from the Florida Medical Association and directed that the component county medical society expel them from membership in that society.

Snake Bites.—Established a Subcommittee of the Board of Governors on Venomous Snake Bites.

Fee Schedules.—Adopted the recommendations of the Fee Schedule Committee as follows:

1. That the 1960 California Relative Value Study be used as a guide for consideration, negotiations, decisions, et cetera, by the Florida Medical Association.
2. That the California Relative Value Study, its nomenclature, code numbers, ground rules, with modifications to bring it into line for Florida, be adopted.

Blue Shield.—Unanimously approved the recommendations of the Committee on Advisory to Blue Shield that the proposed senior citizens contract concerning special low income provisions be accepted in principle.

Members Insurance.—Approved recommendations of the Committee on Members Insurance broadening coverage of the Association-sponsored disability program.

Podiatry.—Approved the recommendation of the Council on Allied Professions and Vocations that the application of the Florida Podiatry Association be approved and that podiatry be officially recognized as an allied profession or vocation.

Medicare.—Approved the recommendations of the Medicare Mediation Committee that the Medicare contract be continued for another year.

National Foundation.—Approved the recommendation of the Council on Voluntary Health Agencies that the National Foundation be granted official recognition.

Awards.—Selected a recipient of the A. H. Robins Co. award "For Outstanding Community Service by a Physician" and the third recipient of the Association's Certificate of Merit from nominations submitted by the county medical societies.

News

Dr. Hayden C. Nicholson, formerly executive director of the Hospital Council of Greater New York, has been appointed Dean of the University of Miami School of Medicine. Dr. Nicholson will assume his duties about July 1.

The sixteenth annual meeting of the Florida Association of Blood Banks will be held in Orlando at the Cherry Plaza Hotel May 18-20. Included on the program will be panel discussions on laboratory procedures, technical aspects of blood banking, topics of administrative interest and an address by Dr. Keith D. McMilan of Eugene, Ore., president of the American Association of Blood Banks. Dr. John A. Shively of Bradenton becomes president of the Florida Association of Blood Banks at the Orlando meeting.

Applications for space in the scientific exhibit of the meeting of the Southern Medical Association in Miami in November are now being received. The Association particularly desires outstanding exhibits from Florida physicians. Chairman of the Committee on Scientific Exhibits is Dr. George F. Schmitt, 30 S.E. 8th Street, Miami.

The full text of the laws relating to the care and treatment of the mentally ill and handicapped, and the laws establishing the Council on Mental Health and the Divisions of Sunland Training Centers and Mental Hospitals under the Board of Commissioners of State Institutions has been reproduced in pamphlet form and is available upon request from the Florida Association for Mental Health, Box 5841, Jacksonville 7.

The Seventh Biennial Cardiovascular Seminar sponsored by the Heart Association of Miami is being held May 17-19 in the Eden Roc Hotel at Miami Beach. Dr. Edward W. St. Mary of Miami is chairman.

Physicians with diabetic children in their practice who may be interested in a summer session at Camp Immokalee on Lake Brooklyn at Keystone Heights, Fla., should contact Dr. Richard H. Sinden, 501 11th Street North, St. Petersburg 2. The Florida Diabetes Association has made arrangements for the camp which begins August

19 and continues through September 1. In addition to Dr. Sinden, the special camp committee consists of Drs. Joseph C. Shipp of Gainesville, Matthew E. Morrow of Jacksonville, Seymour L. Alterman of Miami Beach and Theodore F. Hahn of DeLand.

Dr. Richard E. Strain of Coral Gables, Associate Clinical Professor of Neurosurgery at the University of Miami School of Medicine, has been invited to lecture in Johannesburg, Africa, on July 18-19. Under auspicies of the State Department, he will lecture in Nairobi and Addis Ababa, and then will travel to Odense, Denmark, for the annual meeting of the Scandinavian Society of Neurosurgeons on August 27-28 where he will present a paper.

The 108th annual session of the Medical Association of Georgia will be held May 6-9 at Savannah. Among the speakers on the program are Drs. Joseph A. J. Farrington of Jacksonville and Joseph H. Davis of Miami.

The ruling of the Florida Industrial Commission recommended by the Medical Fee Schedule Advisory Committee to the Commission at its meeting on March 6 has been circulated to all members of the Association. A copy of the ruling was enclosed with the newsletter, "Briefs," number 182 dated April 3.

Dr. Charles K. Donegan of St. Petersburg was inaugurated as president of the American Society of Internal Medicine at the Sixth Annual Meeting held April 6-8 at Philadelphia.

The Ninth Annual Meeting of the Florida Medical Assistants Association is being held June 1-3 at Lakeland. Among the principal speakers are Dr. Robert E. Zellner of Orlando, President-Elect, Florida Medical Association, and Dr. Jere W. Annis of Lakeland, a Past President.

Dedication ceremonies for the Papanicolaou Cancer Research Institute at Miami are scheduled for 2:00 p.m., Sunday, May 13, according to announcement by Dr. Ralph W. Jack of Miami, who is in charge of the event. A dinner that evening at the Everglades Hotel will be in honor of the late Dr. George N. Papanicolaou. All Florida physicians are invited to the dedication ceremonies and to the dinner.

Meetings

May

Florida Medical Association, 88th Annual Meeting, May 10-13, Hotel Americana, Miami Beach

Seventh Biennial Cardiovascular Seminar, Heart Association of Greater Miami, May 17-19, Eden Roc Hotel, Miami Beach

Florida Association of Blood Banks, Sixteenth Annual Meeting, May 18-20, Cherry Plaza Hotel, Orlando

Florida Thoracic Society, May 21, Deauville Hotel, Miami Beach

American Thoracic Society, Medical Sessions, May 21-23, Deauville Hotel, Miami Beach

June

American Medical Association, Annual Meeting, June 24-28, Chicago

Woman's Auxiliary

Annual Meeting — Woman's Auxiliary

The Woman's Auxiliary will meet in conjunction with the eighty-eighth annual meeting of the Florida Medical Association. New officers will be installed and activities for the 1962-63 year will be planned. The convention will be held at the Hotel Americana, Bal Harbour, May 10-12.

Mrs. Edward W. Ludwig of Jacksonville will be installed as the new state president by Mrs. Roy Douglass of Huntington, Tennessee, President of the Southern Medical Association Auxiliary.

All doctors attending the convention are particularly invited to be present for an address by the guest speaker, Princess Catherine Caradja of Rumania, who escaped from behind the Iron Curtain in 1952. Since World War I, Princess Caradja has devoted her life to humanitarian service. She maintained a foundation for orphans until the Communists took it over in 1949. The Princess is well known for the role she played in befriending American flyers caught behind enemy lines during World War II. Since her escape from Rumania, Princess Caradja has devoted herself to informing people of conditions behind the Iron Curtain.

This year Broward County is responsible for convention planning. Mrs. Joseph M. Hopen is Chairman for the Woman's Auxiliary. Mrs. Harry C. Jelstrom and Mrs. Royle B. Klinkenberg are co-chairmen.

Mrs. Charles E. Lowe



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New Members

The following doctors have joined the State Association through their respective county medical Societies.

Active

Bramlitt, Chas. H., St. Petersburg
McKnight, William J., St. Petersburg
Madry, James T., Melbourne
Meyer, William H. Jr., Fort Pierce
Michaelos, Louis J., Largo
Saporito, Charles J., Tarpon Springs
Sclar, Meyer, Miami Beach
Stampa, Julian M., St. Petersburg
Trop, Jules, Miami Beach
Wells, Sarah L., Starke
Zeitler, Robert G., Tarpon Springs

Associate

Alstet, Maynard H., Coral Gables
Blake, Eugene L. D., Tallahassee
Cavanagh, Denis, Coral Gables
Duff, Roland D., Haines City
Davis, Josh D., Gainesville
Davis, Nancy L., Miami
Cottrell, William W., Winter Haven
Greer, Pedro J., Miami
Gutierrez, Albert R., Homestead
Hoffman, Charles W. Jr., Hialeah
Hoffman, William P., Coral Gables
Jones, Beverley B., Miami
King, Hueston C., Miami
Lipton, Roger A., Sarasota
Newman, Ernest G. Jr., Gainesville
Silverberg, Marvin M., Miami

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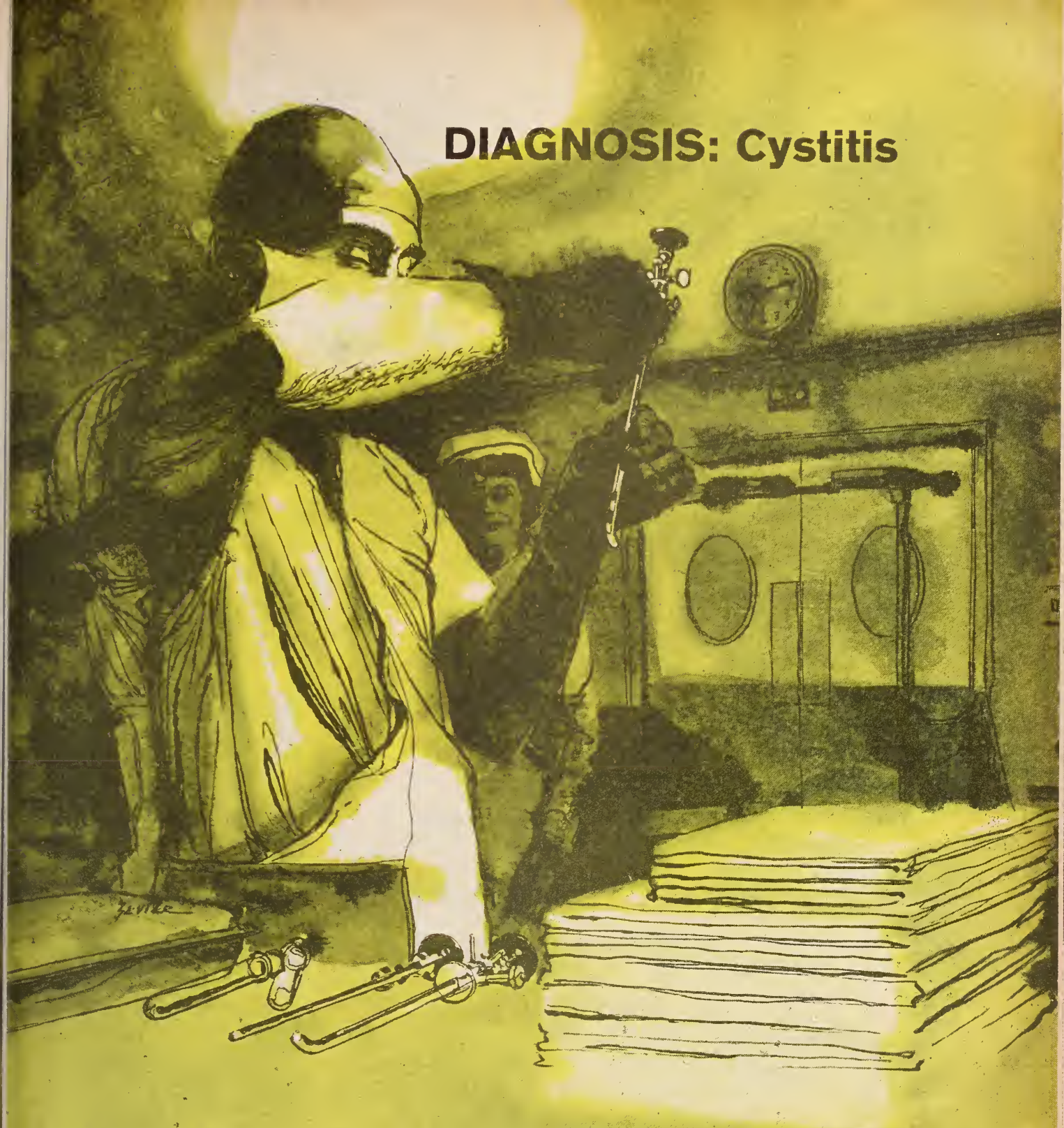
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FOR SALE: Hospital and Mental Institutions; Nursing Homes and Rest Homes in New York City, Westchester, Rockland, L.I., NYS., New Jersey, Connecticut, Pennsylvania, Massachusetts, Florida, Vermont, California, New Mexico, etc. All are profitable operations. Bed capacities from 10 to 300. Cash required $5,000 to $400,000. Some leaseholds. For details contact: Irving Levin, 55 West 42nd St., New York City. Phone CH 4-7310.

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GENERAL PRACTITIONER WANTED: Medical office large enough for two physicians in West Melbourne, the heart of the missile area, the fastest growing county in the United States. 8000 people in the immediate area with no physician. Less than five minutes from new hospital presently under construction in Melbourne. For additional information write Kelly George, Dairy Road, West Melbourne, Florida or phone PA 3-3694.

INTERNIST: Age 46. Certified 1948. F.A.C.P. Florida license. Desires suitable location for solo practice or association. Can invest. Write 69-465, P.O. Box 2411, Jacksonville, Fla.

WANTED: A Pediatrician or a General Practitioner to practice in Brandon, Florida. Have medical building with two examining rooms, a waiting room, office and small laboratory. Contact Ernest Gant, 306 N. Moon Ave., Brandon, Fla.

FOR SALE: One Portable Army Field Keleket X-Ray unit — style 1348 in excellent condition. H. G. Cole, M.D., 1102 W. Cass St., Tampa, Fla.

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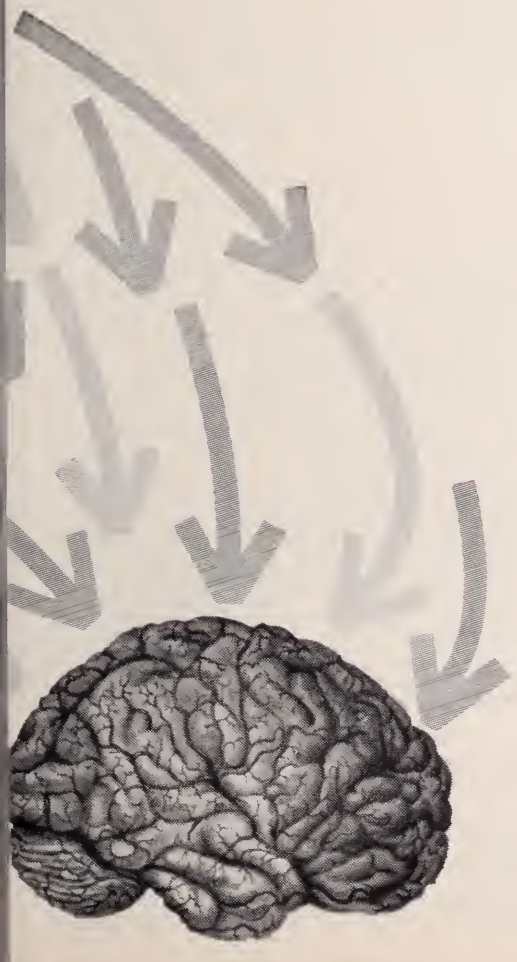
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references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

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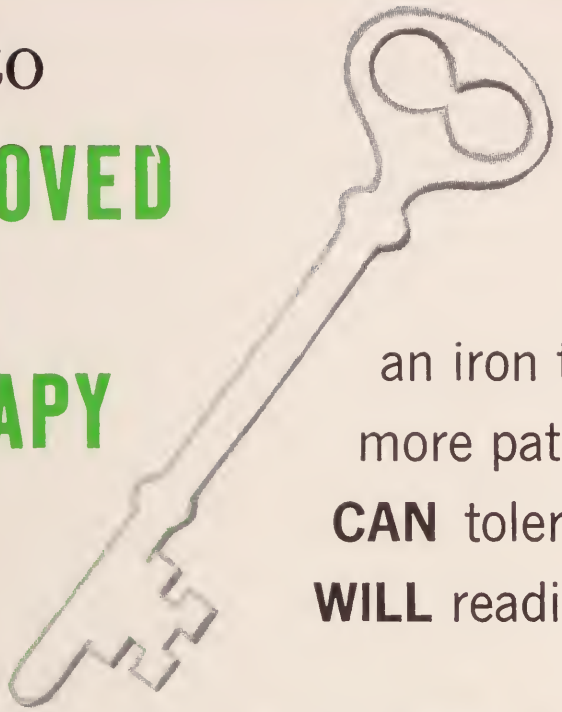
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M. C. Berenbaum, K. J. Child, H. M. Sharp and E. G. Tomich. Blood, The Journal of Hematology, Vol. 15, No. 4, April, 1960. H. T. Swan and G. H. Jowett. British Medical Journal, Vol. 2, October, 1959. J. S. Shapleigh and A. Montgomery. American Practitioner and Digest of Treatment, Vol. 10, No. 3, March, 1959.

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Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

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Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

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And one man in his time
plays many parts,
His acts being seven ages..."*

*As You Like It, Act II, Sc. 7

through all seven ages of man

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in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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See **"IN BRIEF"** on the next page

IN BRIEF VISTARIL®

VISTARIL, hydroxyzine pamoate (oral) and hydroxyzine hydrochloride (parenteral solution), is a calming agent unrelated chemically to phenothiazine, reserpine, and meprobamate.

VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

INDICATIONS: VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

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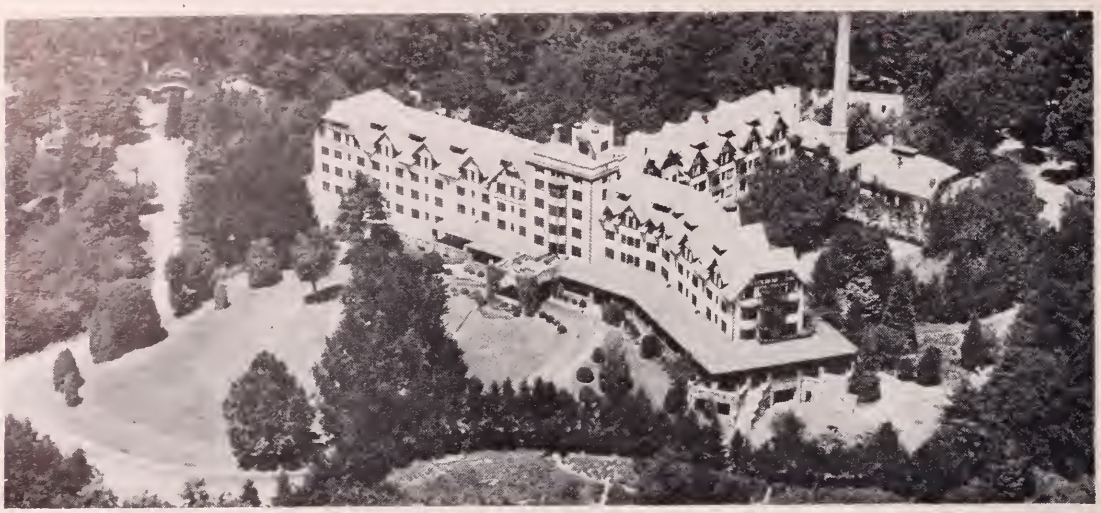
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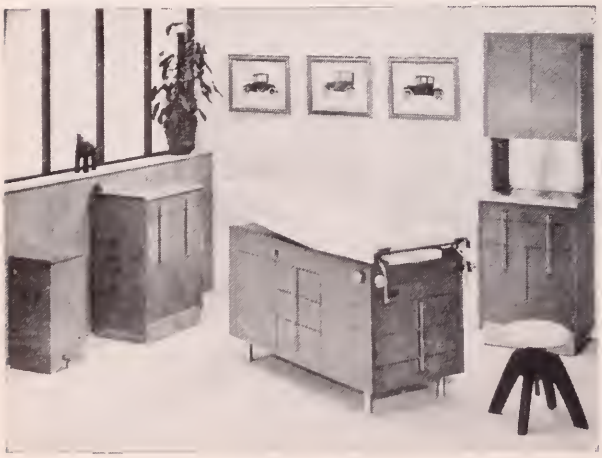
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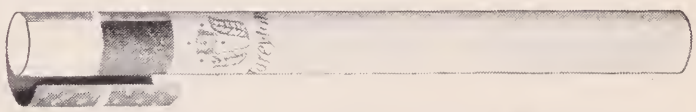
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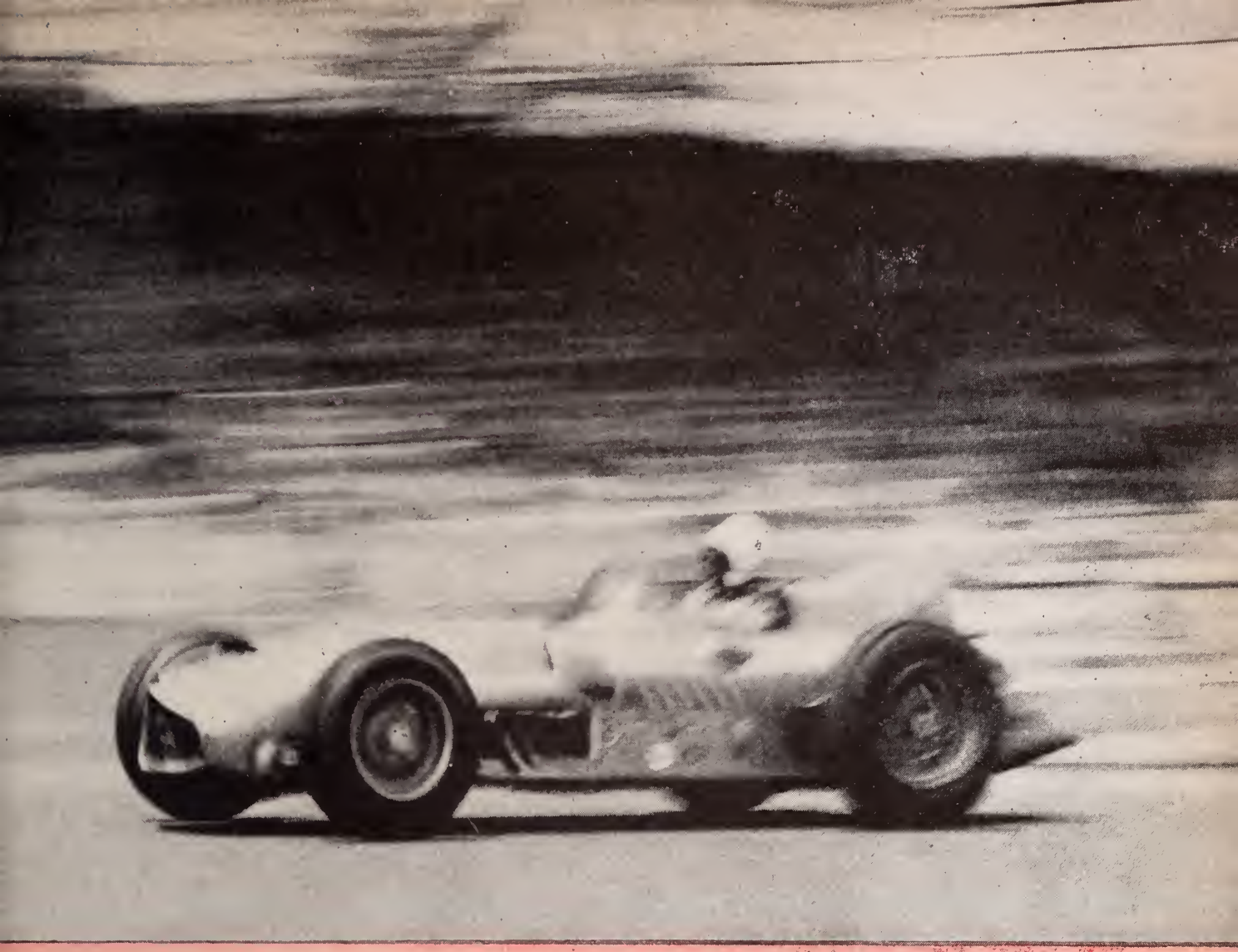
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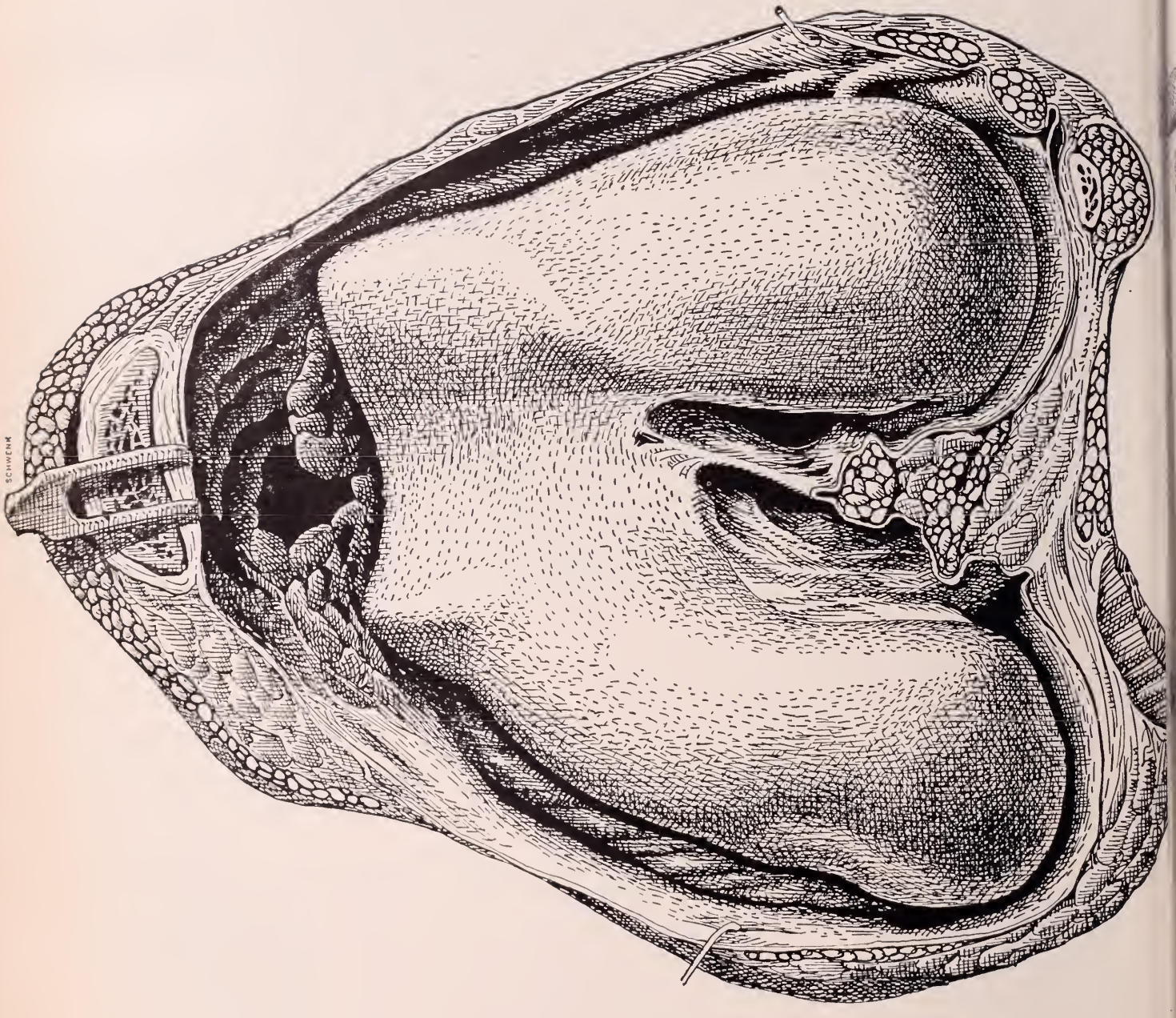
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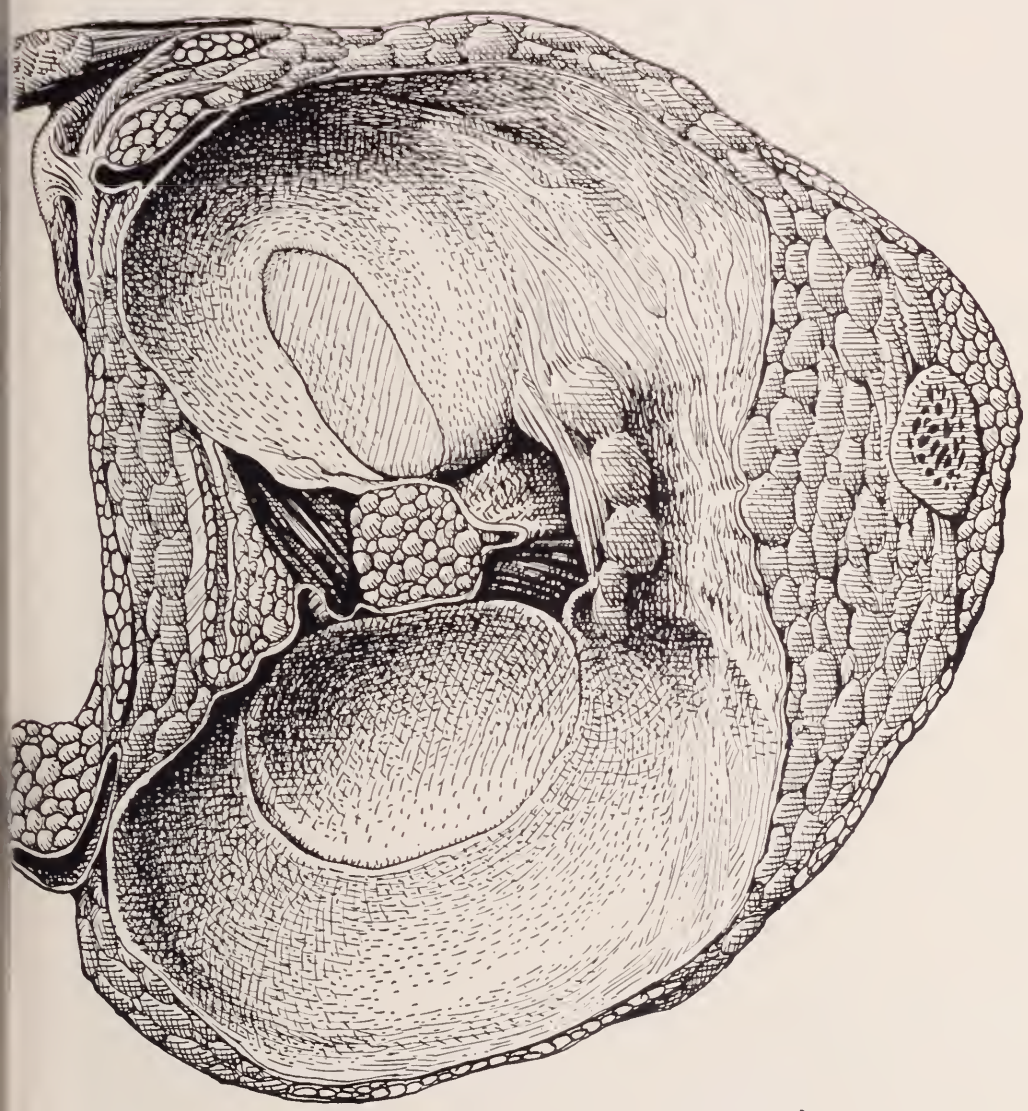
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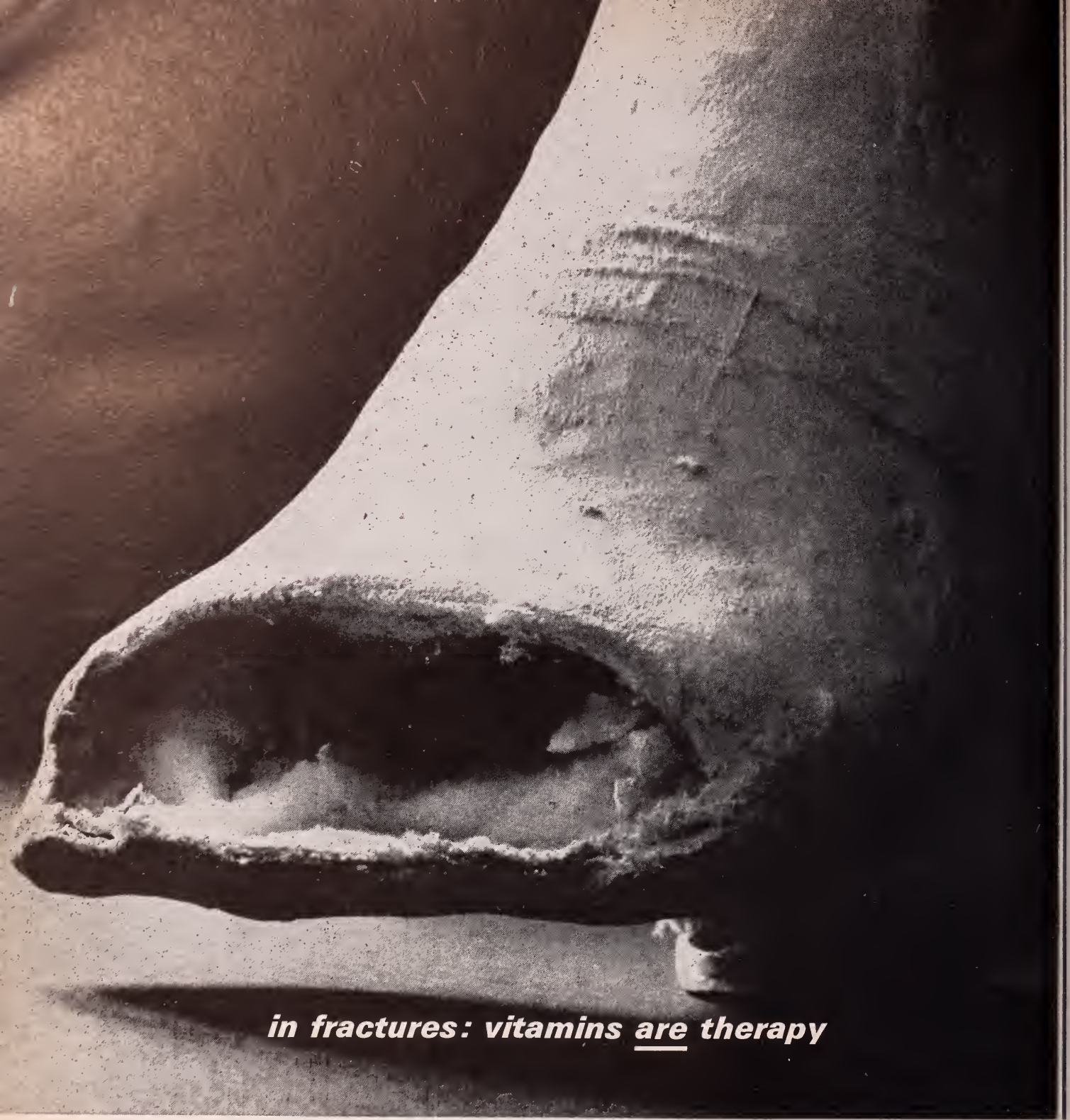
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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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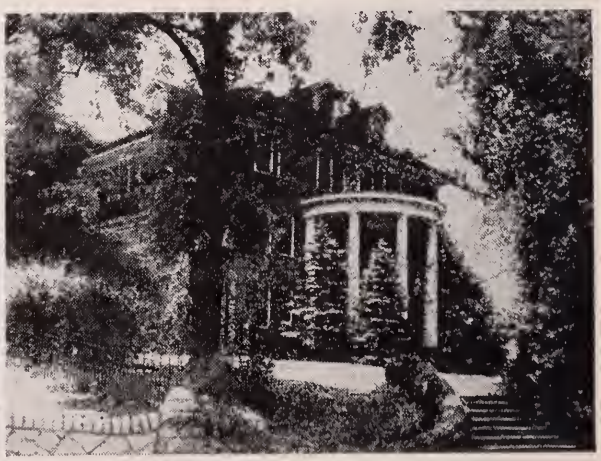
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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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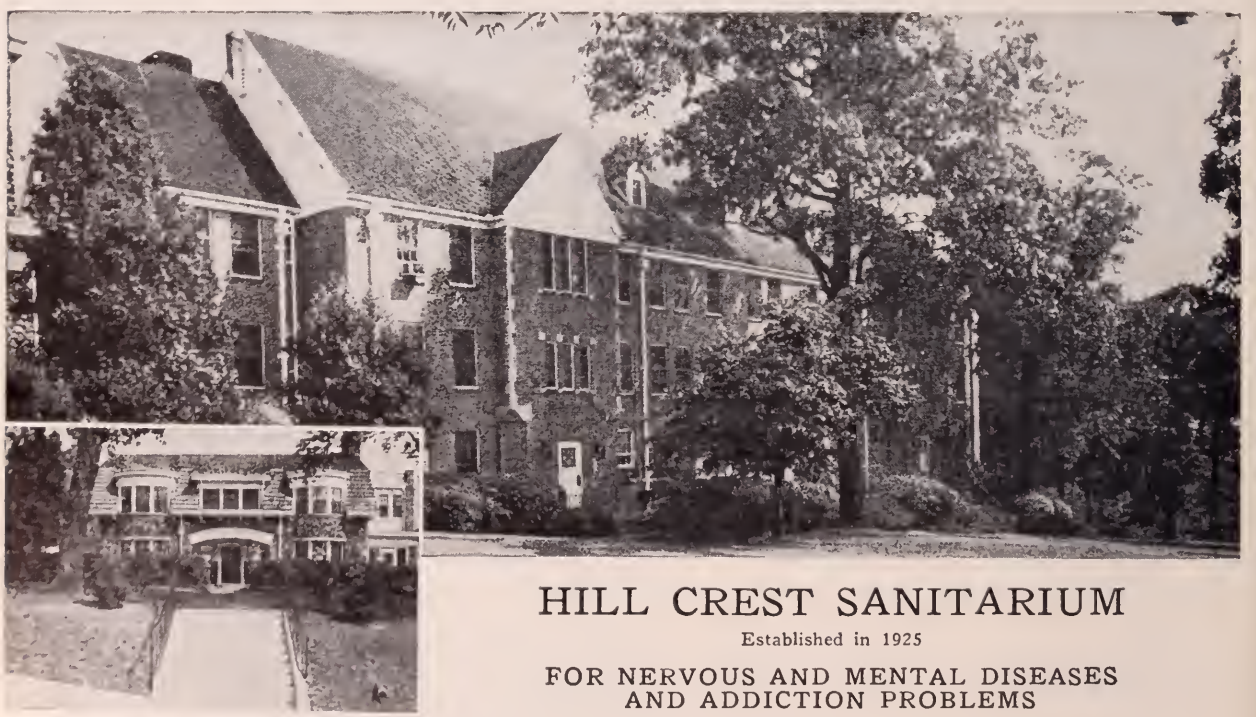
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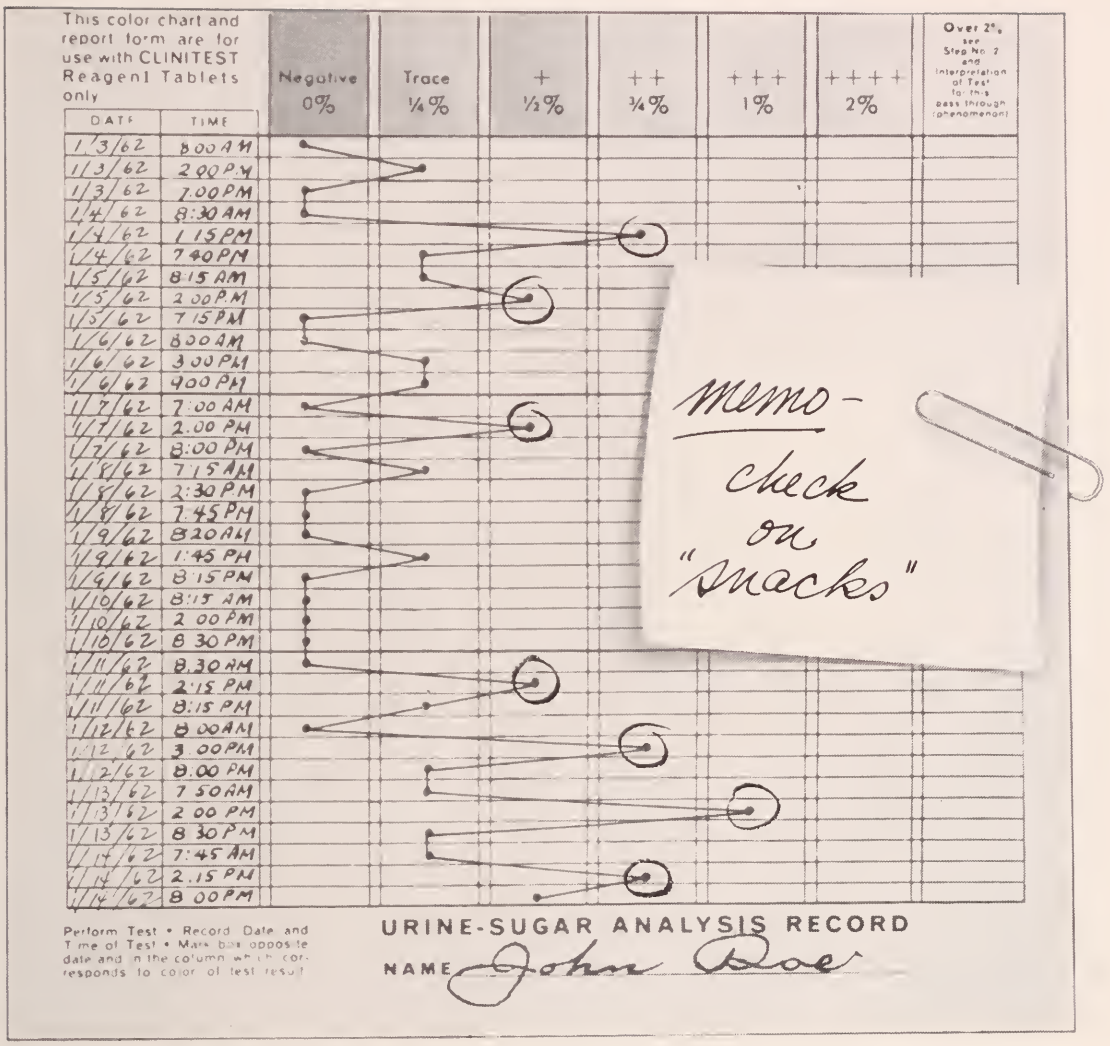
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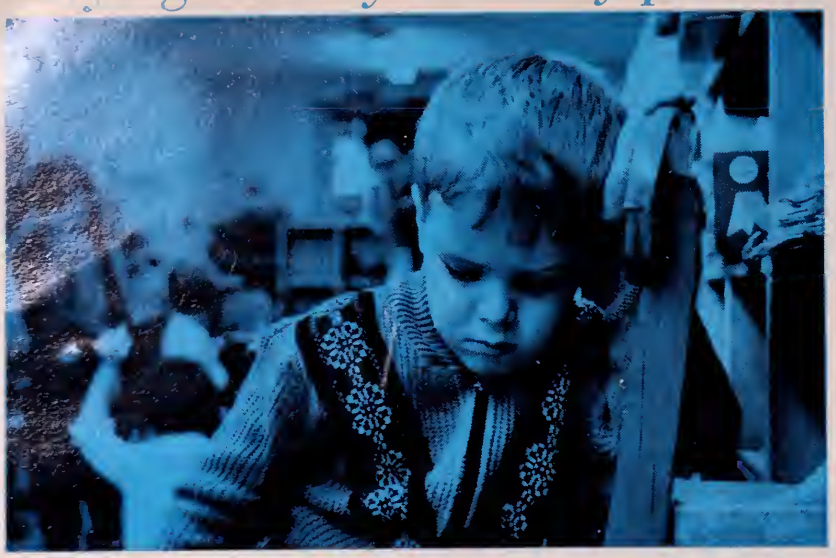
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*Schwartz, I. R.:
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VOLUME XLVIII, No. 12

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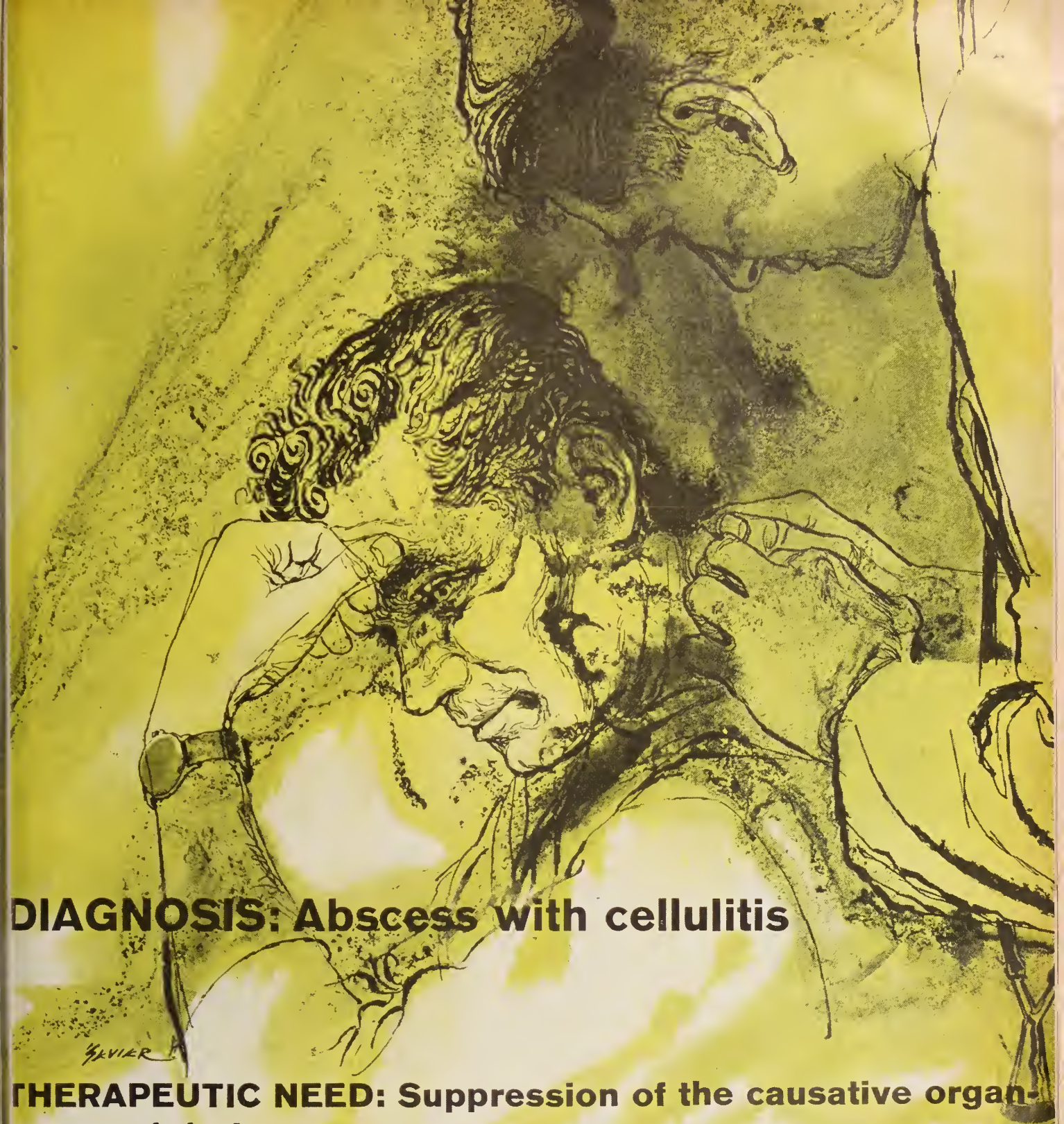


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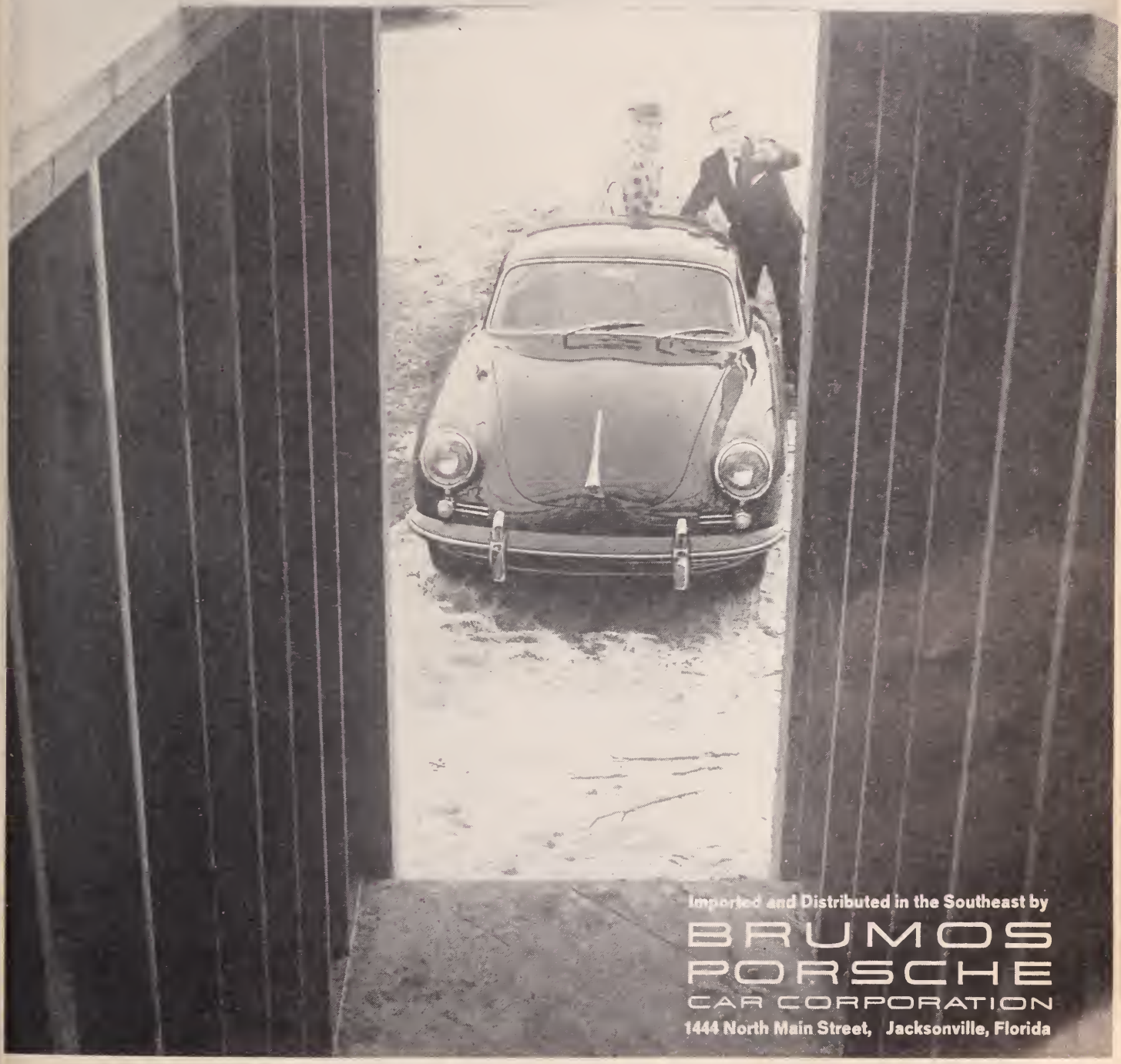
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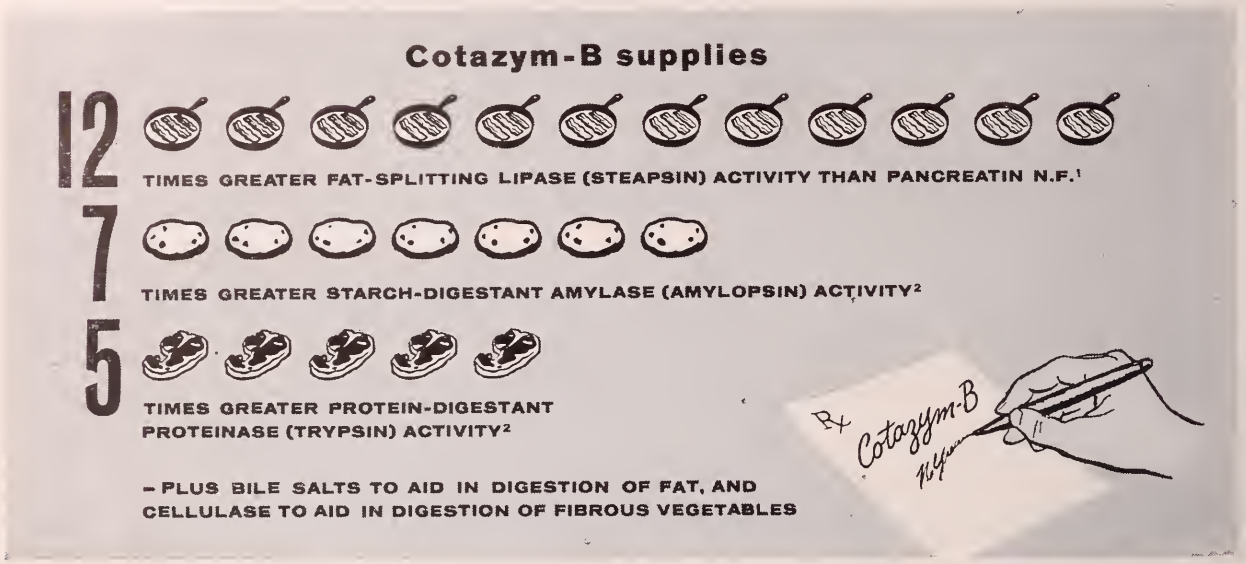
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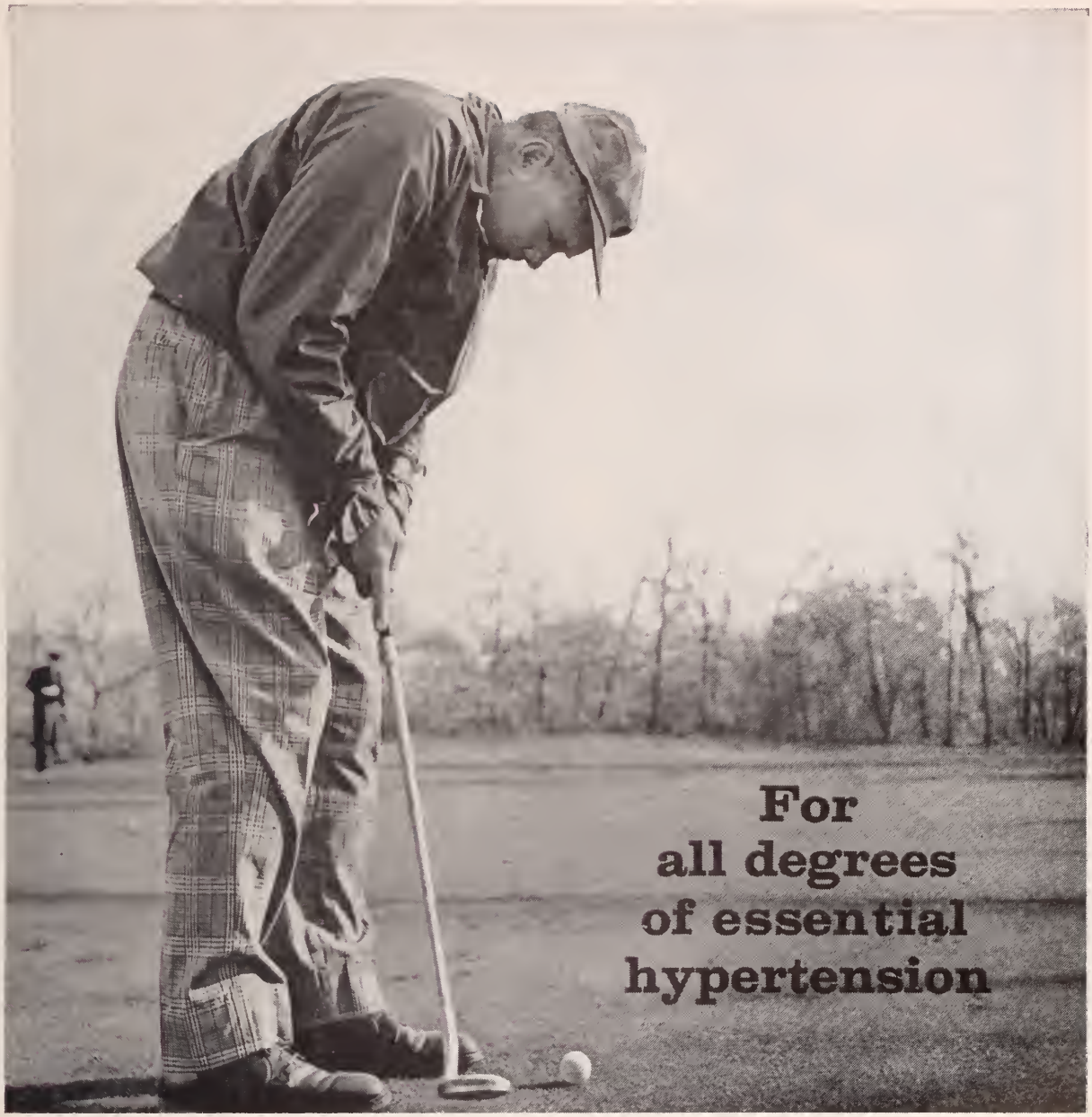
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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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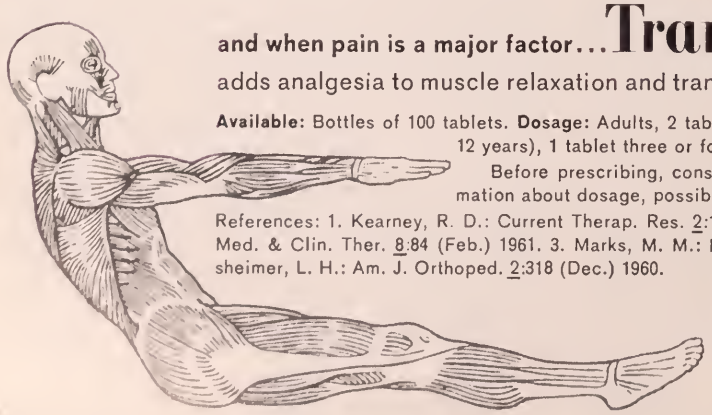
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References: 1. Kearney, R. D.: Current Therap. Res. 2:127 (April) 1960. 2. Cornbleet, T.: Antibiotic Med. & Clin. Ther. 8:84 (Feb.) 1961. 3. Marks, M. M.: Missouri Med. 58:1037 (Oct.) 1961. 4. Hergesheimer, L. H.: Am. J. Orthoped. 2:318 (Dec.) 1960.

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THE JOURNAL
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A New Skin Antiseptic Clinical Evaluation

MARK W. WOLCOTT, M.D., HAROLD S. GOLDSTEIN, M.D.
HERBERT GERSH, M.D., CURTIS G. WHERRY, M.D.
AND SAMUEL TOWNSEND, M.A.
CORAL GABLES

Many agents and techniques have been advocated over the years for the preparation of the skin prior to surgery. We wish to report our clinical experience with a new compound which is a balanced blend of a nonionic detergent (poly-(10)-oxyethylene nonyl phenol), a chelating agent (tetrasodium salt of ethylenediamine tetra acetic acid) and a quaternary ammonia (Benzethonium Chloride U.S.P.).* This will be referred to as Agent I henceforth. In vitro studies carried out on this material since 1957[1] have shown it to be a highly effective germicide in acceptable dilutions and in rapidity of action. The effectiveness was against both gram-positive and gram-negative organisms.

Materials and Techniques

Study and evaluation of this new agent began in August 1958 and was continued until September 1960. Only general, thoracic, and plastic surgical procedures were included in the study. The time was divided into three periods. During period A, from August 1958 until August 1959, Agent I was used in all these surgical procedures carried out in the hospital. During period B, from August 1959 until February 1960, Agent I was compared with a commercially available antiseptic, sodium octylphenoxy-ethoxyethylether sulfonate, lanolin cholesterol and petrolatum,** followed by Benzalkonium Chloride, U.S.P.,*** 1 to 1,000 aqueous solution.

This combination of agents will be referred to as Agent II. Alternate weeks were used for the selection of patients. During period C, from February 1960 until September 1960, Agent I was again compared with Agent II, the two agents being used the night before operation as well as preoperatively during alternate weeks.

There were approximately 730 major and 430 minor surgical patients in the study period A, 100 in period B and 110 in period C (table 1). The following methods of study were carried out: During period A shaving was done just before entry of the patient into the operating theater using Agent I as the shaving "soap." The skin was then scrubbed in the operating room with Agent I for two minutes. No cultural studies were made. During periods B and C cultural studies were carried out by passing a saline saturated cotton swab down and back over the skin exposed through a sterile aluminum template with a 1 by 4 cm. slit in it (fig. 1).

The first culture (tube 1) was taken at the site of the proposed incision prior to shaving the area. The patient was then shaved with Agent I or Agent II depending on the agent being studied that week. The patient was taken into the operat-

Chief, Surgical Service, Veterans Administration Hospital Associate Professor of Surgery, University of Miami School of Medicine (Dr. Wolcott).
Resident, Surgical Service, Veterans Administration Hospital (Dr. Goldstein).
Resident, Surgical Service, Veterans Administration Hospital (Dr. Gersh).
Staff Physician, Surgical Service, Veterans Administration Hospital; Research Instructor in Surgery, University of Miami School of Medicine (Dr. Wherry).
Bacteriologist, Research Department, Veterans Administration Hospital (Mr. Townsend).
From the Veterans Administration Hospital and the University of Miami School of Medicine, Coral Gables.

*Carlendicide produced by the Carlen Research Corporation, Coconut Grove.
**pHisoHex
***Zephiran Chloride.

Table 1

Period	Agent	Patients
A 9 58 - 9 59	Agent I (preoperative only)	730 Major 430 Minor
B 9 59 - 2 60	a) Agent I (preoperative only)	50 Major
	b) Agent II (preoperative only)	50 Major
C 2 60 - 9 60	a) Agent I (preoperative and the night before)	58 Major
	b) Agent II (preoperative and the night before)	52 Major
TOTAL		1370

ing room and prepared with either Agent I or II, by scrubbing the operative field for two minutes. When Agent II was the preparing agent, aqueous Zephiran (1 to 1,000) was painted on the skin after the two minute scrub period; with Agent I no other material was used. The patient was then draped and a swab taken through the template at the site of the proposed incision, in a manner similar to that for the first culture (tube 2). At the time of the initial incision a small piece of skin was taken from the wound edge and dropped into a sterile saline culture tube (tube 3). At the time of the wound closure, another small piece of skin was taken and put into sterile saline (tube 4). After the wound was closed, another swab was taken using a sterile template placed at the edge of the closed incision (tube 5). Twenty-four hours after operation the bandage was removed and using a sterile template, another culture was taken from the wound edge (tube 6).

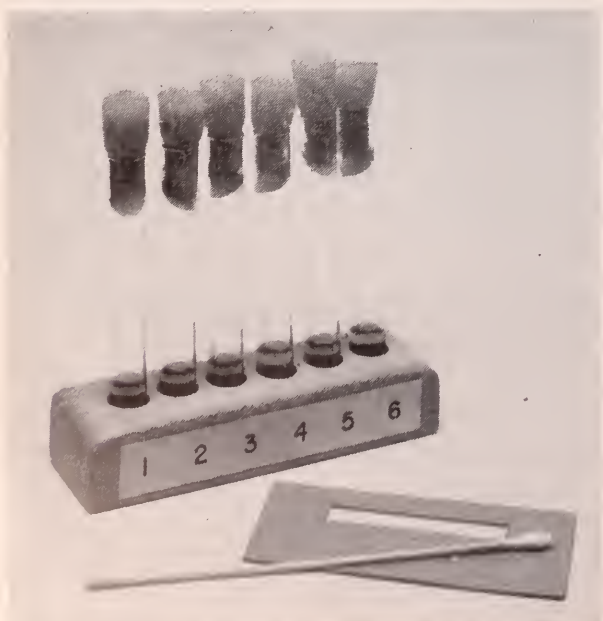


Fig. 1.—Showing template, cotton swab and six tubes containing sterile saline.

Table 2

Period	Type Surgery	Agent	No. Cases	No. Infections	Per Cent Infections
1957 - 1958 (Control)	Major	II	752	35	4.7
	Minor	II	340	5	1.5
	Total		1092	40	3.2
A	Major	I	730	30	4.2
	Minor	I	430	6	1.4
	Total		1160	36	2.5
B	Major	I	50	3	6.0
	Major	II	50	4	8.0
C	Major	I	58	1	1.7
	Major	II	52	2	3.7

Table 3

	Period B 50 Cases Agent I	Period B 50 Cases Agent II	Period C 48 Cases Agent I	Period C 52 Cases Agent II
Initial count below 100	14	22	35	49
Initial count between 100-500	11	11	6	1
Initial count between 500-1000	2	0	1	1
Initial count over 1000	15	10	6	1
After preparation in operating room				
Decrease count	36	40	36	19
Equal count	2	1	8	33
End of Surgery				
Increase count	16	19	6	9
Decrease count	19	7	9	1
Equal count	6	16	33	42
Postoperative—24 hours				
Increase count	25	25	21	23
Decrease count	10	11	24	6
Equal count	4	4	3	23

Results

A. Skin Reactions

No skin reaction was noted in a total of 838 major and 430 minor surgical cases in which the patients were prepared with Agent I in periods A, B and C. There were no skin irritations noted with Agent II. It might be added that during this two year period of study an additional 200 patients with minor staphylococcal infections were treated with Agent I, using this material instead of soap for periods ranging from a few days to two or three weeks, and no skin irritations were noted. The only skin sensitivity during this entire period was one superficial dermatitis in a nurse previously known to react to all types of detergents.

B. Infection Rate

Period A: There were 730 major and 430 minor operative procedures carried out using Agent I as the preparing agent. No orthopedic, neurosurgical, or genitourinary procedures were

included. There were 30 wound infections in major procedures and six in minor surgical procedures for an average of 2.5 per cent (table 2). This period was compared to a period of one year, 1957 to 1958, during which time 752 major and 340 minor surgical procedures were carried out with 35 wound infections in major cases and five wound infections in minor cases for an average wound infection rate of 3.2 per cent. During this year Agent II had been the standard preparing procedure. For these two periods, period A and the year 1957-1958, the number and type of major and minor cases were roughly comparable.

Period B: Fifty patients were prepared with Agent I and 50 patients were prepared with Agent II (table 2). Patients were prepared with Agent I in a total of 21 major abdominal or thoracic cases, 15 hernia cases and 12 other major cases. There were three infections for an infection rate of 6 per cent. Patients were prepared with Agent II in 25 major abdominal and thoracic cases, 18 hernia cases and seven other general abdominal cases. There were four infections in this group or an average of 8 per cent. No minor procedures were studied during period B or C.

Period C: This period involved 110 patients (table 2), of whom 58 were prepared with Agent I and 52 were prepared with Agent II. In the Agent I group of 58 patients there were 20 major abdominal or thoracic cases. 20 hernia cases and 18 other major surgical procedures with infection occurring in one or a percentage of 1.7 per cent. In the Agent II group there were 18 major abdominal or thoracic cases, 22 hernia cases and 12 other major surgical procedures with infection occurring in two for an incidence of 3.7 per cent.

C. Bacteriological Evaluation

Table 3 shows the results of the cultural studies carried out on the patients in periods B and C. From the bacteriological studies we can conclude that Agent I and Agent II are both effective in reducing bacterial counts. Agent I apparently has a longer restraining action on bacteriologic growth as shown by a greater number of reduced counts at the end of surgery in both periods B and C as compared with the culture taken after preparing the skin in the operating room.

Residual action at the 24 hour level is roughly the same for both Agents I and II during period B, but in period C when both agents were used the night before surgery as well as for preoperative preparation, Agent I seems to have a definitely greater residual action at the 24 hour postoperative level.

The results of this study have shown Agent I to be a highly satisfactory agent for the skin preparation. Its value over Agent II is not great at the initial preparation time, but residual action has been better. The amount of Agent I necessary for preparation has been less than one quarter that of Agent II.

The method of cultural evaluation of the preparation routines has been simple, and we believe has yielded highly accurate results.

Summary

Two agents for skin preparation in the operating room have been evaluated utilizing a simplified technique. Results have shown only slight differences between the two when results are evaluated by wound infection rate.

Cultural studies have been similar, showing a definite advantage with Agent I in period C when residual action at 24 hours is compared with counts before surgery. There has been a slight but definite advantage in favor of Agent I on the cultural study as it relates to residual action at the end of surgery in both periods B and C.

No toxicity has resulted from either agent.

Use of either agent the night before surgery reduced the bacterial counts markedly and lowered the infection rate by one half.

References

1. Personal communications from Vincent R. Saurino, Ph.D., Associate Professor of Microbiology, University of Miami School of Medicine, Coral Gables.

1200 Anastasia Drive (Dr. Wolcott).

VOLUME XLVIII
NUMBER 12

An Electronic Cytology Scanning Machine

NELSON A. MURRAY, M.D.
JACKSONVILLE

Large scale screening of the female population for cervical cancer via the Papanicolaou method is already a reality. Over 100,000 slides have been screened in our laboratory alone. If the screened slides are to approach the 20 million mark or higher on a national level, it becomes necessary to employ some instrumentation to eliminate the "most negative" slides. To this end "MESAC," a microscopic electronic scanner and automatic computer for cervical cytology smears, has been developed over the past five years. This instrument, herein described, operates somewhat differently than the "Cytoanalyzer," currently under development and evaluation by the Airborne Instruments Laboratory, the Sloan-Kettering Institute, the American Cancer Society, and the National Cancer Institute. Our instrument is also somewhat more modest, financially.

Design Logic

After personally screening over 100,000 cervical cytology slides and examining an equal number of tissue sections, it is clear to me that the accepted criteria for the identification of malignant cells — nuclear size, nuclear shape, nuclear density, and nucleus/cytoplasm ratio — are on a sound footing and call forth no argument. Additional information, however, relative to cervical smears is peculiar to the cervix itself and is literally "made to order" for electronic prescreening devices. Consider the following facts: 90 per cent of cervical carcinomas are grades III and IV (Broders' Classification); 90 per cent are squamous cell in origin; 90 per cent of asymptomatic cervical carcinomas are of the "in situ" variety. A smear from this type of lesion yields large nuclei with a high nucleic acid content. By suitable preparation, staining, and examination with monochromatic light, the density of the nucleus can be raised above a predetermined threshold level. The nucleus may then be evaluated on size alone. The amount and density of the cytoplasm have little or nothing to do with the identification of a malignant cell. The cytoplasm may be electronically "ignored" by employing a stain that colors the nucleus alone (Schiff reaction). It is at once apparent that the "most negative" slides from in situ cervical carcinomas may be electronically deleted on nuclear size alone.

Following these premises, the development of an electronic instrument for the prescreening of cervical cytology slides was begun. The instrument will not diagnose cancer, nor was it ever intended to do so. Also, it may be noted at this time that patients with presenting gross cervical lesions are likely to have an infiltrating type of carcinoma. Smears from this type lesion contain many small dense nuclei and are not satisfactory for instrumental prescreening at present. The original design premises have remained throughout the design, building and testing of the instrument and are:

1. Malignant cells from an asymptomatic squamous cell carcinoma-in-situ of the cervix have a larger nucleus than do normal cells from the same area.
2. Isolated particles the size of malignant nuclei will occur more often on a positive slide than on a negative slide.
3. If suitably stained, illuminated, magnified, and projected, the images of such malignant nuclei may be caused to generate electrical impulses as they (the nuclei) pass in front of photocells.
4. Such isolated particles the size of malignant nuclei may be counted and totalized electronically, provided that:

   A. Particles smaller than malignant nuclei (in this case, normal nuclei) do not activate the computer.

   B. Particles (trash) and nuclear aggregates larger than malignant nuclei activate the computer in a prescribed manner.

   C. Cytoplasm is rendered transparent by selective staining.

It is believed that the instrument described here satisfies these premises. The idea is graphically illustrated in figure 1.

Operation

To maintain clarity, "tissue cells" will hence-

Director of Research, Murco Research, Inc.
This project was financed in part by a research grant from the American Cancer Society.

forth be referred to as "nuclei" and photoelectric cells as "P.E.C."

The electric transport microscope is constructed so that the slide is scanned automatically according to figure 2. The horizontal movement is 30 mm., and the vertical movement is 1 mm. The lengthwise run is made 20 times, so that a field of approximately 600 sq. mm. is scanned. The microscopic image is projected into a screen having 64 photocells arranged in a vertical line. The moving microscopic image travels from side to side, perpendicular to the row of photocells. The magnification is so adjusted that a normal nucleus just darkens one photocell, and a malignant nucleus just darkens two adjacent photocells. A trash particle or nuclear aggregate will darken three or more adjacent photocells.

Each photocell has its own individual amplifier. The amplifiers activated by each two adjacent photocells are connected to the input of an "and" type gating circuit with two inputs. The gate output is connected to a counting device, so that one count will be recorded each time two adjacent photocells are darkened simultaneously (malignant nucleus). The outputs of all "two gate" circuits are connected in parallel. Likewise, the amplifiers activated by three adjacent photocells are connected to the input of an "and" gating circuit with three inputs; the gate output is connected to a second counting device, so that one count will be recorded on this second counting device each time three adjacent photocells are darkened simultaneously (trash or nuclear aggregate); the outputs of all "three gate" circuits are connected in parallel. If only one photocell is darkened (normal nucleus), neither the "two gate" nor "three gate" counter will be activated, and no count will be recorded. It is also apparent that for each impulse recorded on the "three gate" counter, two false impulses will be recorded on the "two gate" counter as a result of the "reasoning" of the computer. Thus, to arrive at the "true" count of particles the size of malignant nuclei, the following formula must be applied:

G_2 = total two gate count; G_3 = total three gate count; TC = true (corrected) two gate count

Then: $G_2 - 2\,G_3 = TC$

Example:

Two gate counter reads 8420
Three gate counter reads 2640

Then the true two gate count (TC) is:

$8420 - 2\,(2640) = 8420 - 5280 = 3140$

The number 3140 is theoretically the number of particles the size of malignant (size of two P.E.C.) nuclei passing under the microscope in a given interval. It is realized that leading and trailing edges of nuclei, partially darkened photocells and isolated nuclei passing widely separated parts of the P.E.C. bank simultaneously will affect the final count. Nuclei approaching the photocell bank at an angle will also affect the final count. These random events will occur on all slides, however. A block diagram of the entire instrument is shown in figure 3. Only one "sens-

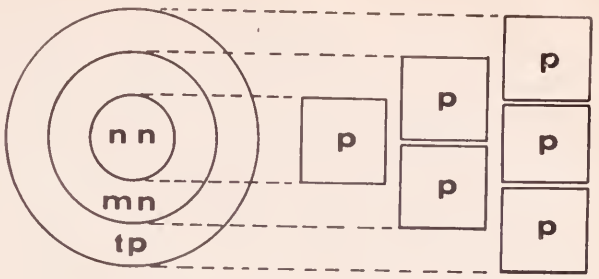


Fig. 1.—Sizes of particles scanned compared with size of photocells. NN = normal nucleus (size of one photocell); MN = malignant nucleus (size of two photocells); TP = trash particle (size of three or more photocells).

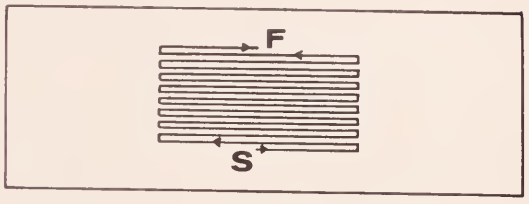


Fig. 2.—Pattern of smear movement as slide is scanned by instrument; S = start of scan; F = completion of scan.

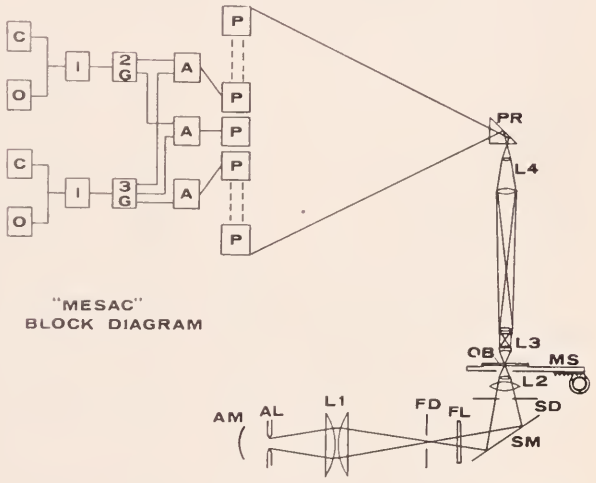


Fig. 3.—Block diagram of complete instrument. AM = arc lamp mirror; AL = arc lamp; L_1 = arc lamp condenser; FD = arc lamp field diaphragm; FL = filter; SM = substage mirror; SD = substage diaphragm; L_2 = substage condenser; MS = motorized microscope stage; OB = object slide; L_3 = microscope objective lens; L_4 = microscope eyepiece lens; PR = prism; P = bank of 64 photocells; A = photocell amplifiers; 2G = two gate circuit; 3G = three gate circuit; I = phase inverter and booster amplifiers; C = readout counters; O = monitoring oscilloscopes.

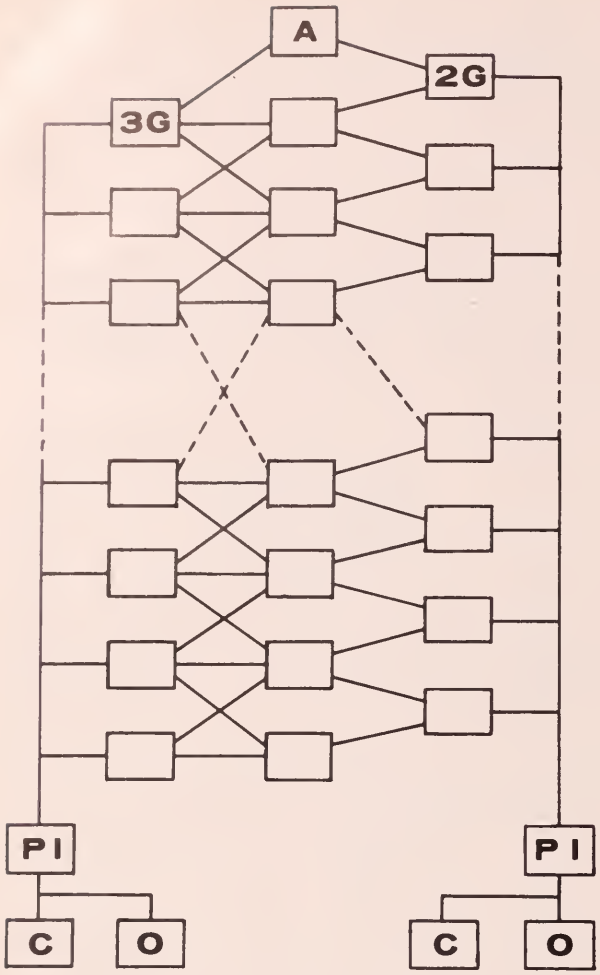


Fig. 4.—Block diagram of complete computer showing series gating circuit connections. Middle row (A) = photocell amplifiers (64 total); right hand row (2G) = "and" type gating circuits with two inputs (63 total); left hand row (3G) = "and" type gating circuits with three inputs (62 total); PI = phase inverter and booster amplifiers; C = readout counters; O = visual monitoring oscilloscopes.

ing" unit is shown. A more complete block diagram of the computer is shown later. The individual parts of the instrument will now be described in some detail.

A. The Microscope

The electric transport microscope is a Leitz body focusing type equipped with a specially machined, electrically operated stage. The stage does not actually touch the microscope, but travels back and forth beneath the objective lens in a predetermined pattern. The stage is powered by a reversible D.C. motor geared down so that the stage makes approximately 15 lengthwise passes per minute beneath the objective lens. The stage and motor mount are machined from heavy chrome steel plate to a tolerance of 0.0001 inch. The controls are arranged so that as much of a slide can be scanned as desired. At present the scan rate is approximately 600 sq. mm. per minute per slide. The speed appears near optimum. The total area to be scanned is not definitely fixed at present. The slide may be stopped, examined visually, reversed or started again at any time during the scan. The slide is automatically reversed at the end of each cycle by suitable microswitches and relays. The electrical components for operating the microscope are all shielded and bonded to the microscope.

B. The Source of Illumination

The source of illumination is a Hanovia #528B high pressure quartz Mercury-Xenon arc lamp rated at 1 kilowatt. The high intensity arc measures 7 by 1 mm., and emits 220 candles/mm. The total lumen output is 52,000. It operates at 65 volts D.C. and 16 amperes. This lamp is far superior to numerous lamps tested. The power supply has been completely reworked and heavily filtered. The filter section is 10,000 mfd. plus a choke coil from a 100 ampere welding machine. This extensive filtering is necessary to keep the AC pulses out of the computer. The lamp is forced air cooled to prolong its life. The lamp housing is designed to bathe the entire lamp bulb with rapidly circulating air. A metal mirror reinforces the arc; the composite arc and image are focused on the microscope substage plane mirror by a 75 mm. coated anastigmatic lens. The image of the arc can be clearly seen on the substage diaphragm. The arc is struck with an auxiliary radio frequency generator.

C. The Photoelectric Sensing Unit

Sixty-four International Rectifier self-generating selenium Photovoltaic cells, each employing a 25 sq. mm. sensitive area, are arranged in a vertical line, intercepting the center of the projected microscopic image as it moves from side to side. The light falling on each photocell generates less than 1 microampere. The usual signal is less than 5 milliseconds duration. The photocells are electrically shielded in all directions except for a 5 mm. slit to admit the projected image. The top 32 P.E.C. are cabled via a shielded cable to a 32 connector shielded plug. The bottom 32 photocells are likewise cabled to a 32 connector shielded plug. The two shielded plugs mate with two shielded sockets in the computer case.

D. The Computer and Readout Circuits

The computer is housed in a shielded cabinet. The entire inside is coated with three coats of pure metallic silver baked onto marine plywood.

Each of the 191 printed circuit boards is shielded from the adjacent board by two sheets of copper plastic laminate. The computer consists of 64 transistor amplifiers of four stages each, 63 "and" type gating circuits with two inputs, 62 "and" type gating circuits with three inputs, two phase inverters, and two booster amplifiers. A total of 385 transistors and 375 diodes is employed. Each of the 64 P.E.C. energizes its own amplifier. The pulse is shaped within the amplifier; the positive component is clipped, and the emerging signal is a negative going square wave pulse. These pulses are strictly on a "go-no-go" basis, according to the threshold setting for nuclear density. When pulses occur in the proper sequence, a "two gate" or "three gate" signal is generated. The signal leaving the gating circuit is a positive going square wave pulse. The pulse is steered by a reverse biased silicon diode into the phase inverting circuit. The pulse leaving the phase inverter is a negative going square wave pulse. This pulse is reinforced (but not inverted) by a booster amplifier and fed into the readout circuit.

The readout counters are Hewlett - Packard Model 521 C Industrial electronic counters. The two counters have built-in crystal calibrators and operate up to 100 KC/sec. An oscilloscope is connected in parallel with each counter so that visual monitoring of the pulses is possible at all times. By reverse biasing the output silicon diodes in the gating circuits, the noise level of the computer has been reduced to zero for all practical purposes. The computer power consumption is less than 0.1 watt.

The instrument will completely scan a blank slide (one full minute) with a zero reading on both counters; no oscilloscope pulses will be seen during the entire scan. A block diagram of the electronic circuitry is shown in figure 4.

Preparation of Standard Test Slides

Over 100 different types of material and over 2,000 slides have been evaluated. Photographic reproductions, bacteria and nucleated blood cells were not satisfactory. Of all materials used, glass beads were the most satisfactory. Beads are now available from 2 microns to 100 microns in diameter. The beads are suspended in 95 per cent alcohol, sized by elutriation, and atomized onto microslides at a distance of 50 cm. and 10 lb/sq. in. gauge pressure. A 22 gauge hypodermic needle is used for the atomizer nozzle. This technique results in uniform particle distribution (10-20 particles/mm.) and minimum numbers of aggregates. This population density is acceptable to the computer. Special Hordis* microslides with a maximum variation in thickness of 7.5 microns were used to prepare all of the slides.

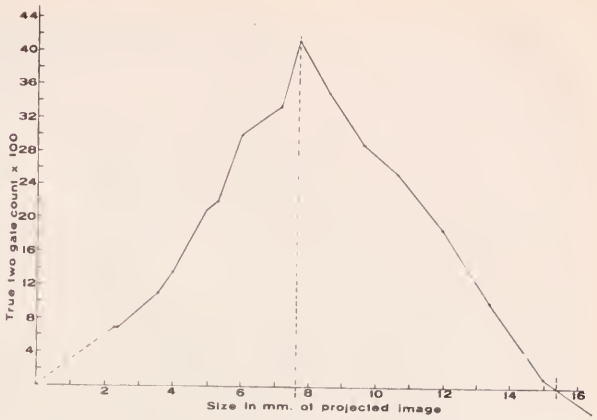


Fig. 5.—Graphic representation of table 1, showing projected image size of particles (abscissa) plotted against corrected two gate count (ordinate).

Table 1.—Tabular Representation of Changes in Corrected "Two Gate" Counts with Changes in Size of Projected Particle Images

Magnification	Mm. Size Screen Image	G_2 Count	G_3 Count	G_3X2	G_2-2G_3
64	1.9	815	95	190	625
72	2.2	847	72	144	700
80	2.4	842	70	140	700
88	2.6	877	97	194	680
120	3.6	1490	187	374	1115
135	4.0	1802	222	444	1360
150	4.5	2220	247	494	1725
165	5.0	2642	257	514	2130
175	5.3	2540	160	320	2220
200	6.0	3435	200	400	3035
226	6.7	3770	275	550	3220
240	7.2	3970	305	610	3360
256	7.7	5255	535	1070	4185
288	8.6	5010	760	1520	3490
320	9.6	4600	845	1690	2910
352	10.6	4700	1060	2120	2580
400	12.0	4440	1270	2540	1900
450	13.5	4300	1670	3340	960
500	15.0	4280	2080	4160	120
550	16.5	4100	2215	4430	-330

Results

Table 1 and figure 5 show that the instrument behaves as predicted. By varying the size of the projected images of the glass beads, maxima and minima are established for corrected "two gate" counts. The maximum true "two gate" count occurs near 8 microns. As the size of the projected particle images approach the size of three adjacent photocells, the corrected "two gate" count approaches zero, as predicted. Also, as the size of the projected particle images becomes smaller and smaller, the corrected "two gate" count approaches zero. The manner, however, in which the large image counts approach zero is orderly.

*Capital Surgical Supply Company, Harrisburg, Pa.



Fig. 6.—Photograph of entire instrument. Cabinet with meters (lower left) is power supply and blower for arc lamp. Box to right of microscope houses stage mechanism. Box to far right houses stage controls. Lamp house is directly in front of microscope; photocells are seen as black vertical line in center of screen; single photocell and meter attached to top of screen is light level indicator; tall cabinet in rear houses computer; read-out counters and oscilloscopes are seen at left rear.

The manner in which the small image counts approach zero is erratic; these counts are actually tiny random aggregates, and are not significant. Table 1 and figure 5 confirm these observations.

A photograph of the completed instrument is shown in figure 6.

Conclusions

An instrument is described which will automatically scan microparticle preparations and electronically separate and totalize particles the size of malignant nuclei and particles the size of non-malignant nuclei.

With proper programing, this instrument will automatically delete the "most negative" cervical cytology slides from a group showing nonmalignant nuclei and malignant nuclei of squamous cell epithelioma-in-situ.

The instrument will not diagnose cancer.

Any woman presenting a gross cervical lesion or abnormal vaginal bleeding not associated with pregnancy may harbor a small cell type infiltrating cervical carcinoma and is a candidate for biopsy. Cytology studies on this type of patient are not amenable to instrumental "prescreening" at this time. These smears require expert individual interpretation, and even then are inadequate when employed alone.

The clinical, cytopathological and instrumental aspects of an electronic prescreening program are integral parts of a single problem and should be evaluated simultaneously.

References are available from the author on request.

The author wishes to express his sincere appreciation to Drs. Geo. Z. Williams and H. D. Van Schaick for their continued encouragement and counsel throughout the duration of this project; to Drs. W. B. Courtney, S. C. Ingraham II, and J. C. Pruitt for the loan of prepared slides, and to Mr. R. D. Manners for his untiring technical assistance in the preparation of the many printed circuits. For the almost unlimited supply of classified microparticles special thanks is extended to Dr. J. W. Vanderhoff of the research department of the Dow Chemical Company, Mr. R. G. Buehring of the Minnesota Mining and Manufacturing Company, Mr. W. F. Swann of the Eastman Kodak Company, Mr. E. L. Wiegand, of Wiegand Industries, Mr. E. K. Bastress of the Princeton University School of Engineering, the Stanford University Particle Bank, and the Utah State University Department of Physics. Without the encouragement and help of these individuals and institutions, this work would have been impossible.

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Cesium 137 Supervoltage Therapy

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The place of cesium 137 supervoltage therapy in the medical armamentarium is now beginning to become crystallized. The relative paucity of factual information on the subject, even in the radiological literature, is striking. It therefore seemed that the nonradiological medical fraternity would be uncertain as to the place or capabilities of cesium 137 in today's therapeutics.

Had the Manhattan Project taken place in 1895 when Roentgen discovered the x-ray, rather than during World War II, it would be interesting to speculate on the subsequent effect on radiology in general and on the treatment of malignant disease in particular. The culmination of the Manhattan Project resulted in man's ability to release tremendous quantities of energy from the atom in a controllable manner. Roentgen's discovery of the x-ray some 50 years prior to the splitting of the atom was a cart-before-the-horse affair. He released energy or x-rays from a metallic target by bombardment with high voltage electricity. The x-rays are merely long wave length gamma rays such as are emitted by radium or any man-made isotope. The x-ray therapy machine is a king-sized diagnostic unit in which 99 per cent of the induced electrical current is wasted as heat. The standard type of x-ray therapy machine has an output of 200,000 to 250,000 volts and has long been designated as orthovoltage. While such units in skilled hands will produce excellent results, no amount of skill will alter the fact that at a dose of about 400 to 500 r, a skin erythema is produced. When a dose of 2,000 to 3,000 r is reached, a moist desquamation results beyond which it is impossible to treat the patient further without producing disastrous results. In addition, these are cumbersome and complicated electrical monsters which are often cranky and unreliable.

In order to overcome the problem of limited treatability of a skin area as well as to increase depth dose and lower the incidence of radiation sickness, larger and more expensive machines were designed which were of the order of 1,000,000 to 2,000,000 volts. Needless to say, this type of equipment is massive and prohibitively expensive and can be found only in well endowed medical centers. To carry this investigation of supervoltage further, the 20,000,000 volt betatron was built. Such assemblies occupy whole buildings. Work to date unfortunately indicates that no matter how high the voltage, such machines cannot cure an incurable cancer. Unless used for research, it would seem that the building of such machines is waste of funds which could be used to better advantage in other medical endeavors.

Since the therapeutic effect of x-rays or gamma rays is approximately the same regardless of the mode of production, one can see the tremendous implications of the results of the Manhattan Project. Practically every known element has been subjected to bombardment in reactors and rendered radioactive. Interestingly enough, each element produces its own characteristic radiations and each of these radioactive elements has its own distinctive half life. These radioactive emissions may range from such feeble energy as the alpha ray, which can be stopped by a sheet of paper, to the very short gamma rays with energies of over a million volts and penetration of several inches of lead. All that is necessary to produce a supervoltage machine is to take a suitable radioactive element and drop it into the center of a large shielded mass or head fitted with a sliding diaphragm which is operated by remote control for a predetermined time. Such a source must have a gamma emission in the supervoltage range and must have a half life long enough so that the source would not have to be replaced or reinforced at close intervals.

Cobalt 60 happened to be one of these suitable radioactive elements. It has a gamma emission of 1,000,000 volts and a half life of five years. Earlier units were loaded with a few hundred curies. Since the treatment time proved to be unduly long with these small loadings, the treatment heads were increased in size and packed with more and more cobalt 60 as this isotope became available in the larger quantities desired. The cobalt 60 source per se is very expensive even when obtained from the Atomic Energy Commission at cost. Such units range in cost from $25,000 to $70,000. This does not include the cost of shielding. Unless built underground, walls of concrete three feet thick are required to attenuate the primary beam. The cost of building such

a shielded room runs into many thousands of dollars. It is therefore evident that cobalt units of more than a few hundred curies are beyond the reach of private offices or small hospitals. Another disadvantage is the fact that the half life of cobalt 60 is relatively short. One per cent of the energy is dissipated each month, requiring constant recalculation of treatment time. This energy is dissipated whether the machine is used or not, and after a few years the source must be exchanged for a fresh one.

Role of Cesium 137

The advent of cesium 137 appears to offer a happy medium. During the late 1940s, cesium 137 was discovered to be one of the high yield fission products of the reactors. By 1950 its radiation characteristics were fairly well known. By 1951 an experimental teletherapy machine was devised and set up in Oak Ridge. Certain unique advantages are associated with cesium 137. The most important advantage is its long half life of 27 to 30 years. It decays at the rate of only 2 per cent per year. It therefore does not have to be reinforced or reloaded. The source is relatively cheap, being a waste product of the reactor. It emits a useful monochromatic gamma beam of an energy over 660,000 volts. The energy of the beam is roughly equivalent to the average from a 1,000,000 volt roentgen ray generator.[1] The attenuation of the emitted beam in high density materials is proportionately greater than for cobalt 60 and therefore the problem of shielding is greatly diminished. Only two thirds of the concrete thickness is required for shielding compared with cobalt 60. Also, because of the previously noted proportionately greater attenuation of the cesium 137 beam in high density materials, the cesium 137 treatment head can be made relatively small, allowing greater maneuverability.

Its other attributes are closely comparable to cobalt 60. There is a skin-sparing effect since the maximum dose occurs 1.5 mm. below the skin. Cesium 137 radiation is absorbed almost equally by muscle, bone and fat. The percentage depth dose achieved is close to that of cobalt 60. Since cesium 137 has the characteristic forward scatter of all supervoltage radiation, there is less radiation to adjacent tissues and lessened volume dose. The tendency toward radiation sickness is therefore diminished. It does not require an electric current for its operation beyond that needed to operate the remote-controlled diaphragm. In the event of electrical failure, the shutter or diaphragm closes mechanically. There is a slightly larger penumbra than for cobalt 60 since the source must be greater in diameter, but this can be trimmed to a minimum. The availability of cesium 137, which was once in short supply, is now plentiful.

Differential Biological Effect of Gamma Ray

The interesting and elusive problem of the differential biological effect of the gamma ray from different sources merits brief discussion. Radiologists are cognizant of the disadvantages of the x-ray beam emitted from orthovoltage equipment such as the excessive lateral scattering of ionization in the superficial layers of tissue with resultant undesirable damage of normal tissue. The multimillion supervoltage machines on the other hand produce a tremendous localized forward scatter of "harsh" radiation which ionizes everything in its path. While it is true that the maximum dose occurs lower than 1.5 mm. below the skin, the latent effects of such radiation are not entirely known, but it is suspected that excessive fibrosis is produced. The beam from cesium 137, being in the median supervoltage region, also skips the skin, but its depth dose is more controllable. There is also the impression that due to its median intensity, the quality of its gamma ray is therapeutically more effective. This has not been proved clinically, but on theoretical grounds it is logical since the ray is of a "milder" type and because its depth dose can be pinpointed. This latter quality is unique to cesium 137. Because of its median supervoltage range, this is the only type of equipment which lends itself to manipulation of the source-skin-distance by a series of cones. This results in a wide range of depth dose distribution. In practice, it means that a wide variety of lesions can be treated by one such machine from superficial head and neck lesions to deep-seated abdominal neoplasms.

Advantages of Cesium 137

What does the foregoing mean from the practical standpoint? It means that the patient requiring supervoltage therapy can be treated more economically. It means that such therapy can be brought closer geographically, avoiding the need of travel to large medical centers. It means that the patient, already suffering from a serious malady, will not be made miserable by the necessity of producing moist desquamations to obtain an adequate depth dose. This is a most important point. The British therapeutic radiologists have in past years rightly chided us for not treating

our patients adequately for fear of producing moist desquamations. Paterson[2] stated in his classical textbook: "The sequence of changes occurring in the irradiated normal tissues and in the tumour following irradiation . . . constitute the 'reaction' which must always follow treatment which seeks to eradicate malignant disease, and must not be counted as too high a price to pay for the possibility of cure. Although such a reaction must be accepted as inevitable, every effort should be made to mitigate the discomfort by careful nursing."

Furthermore, it means that better palliation can be achieved with a lessened chance of radiation sickness. There is also the diminished possibility of pathological bone fracture since absorption in bone is less than with orthovoltage. While the erythema dose with orthovoltage is about 450 r, that with cesium 137 is about 2,000 r. While the epilation dose with orthovoltage is about 400; that with cesium 137 is about 1,500 r.

The fact that there has been a sharp curtailment in the manufacture of roentgen ray generators is evidence of their diminishing clinical importance and unnecessary complexity.

The late Dr. Cornelius P. Rhoads, Director of the New York Memorial Hospital, categorically stated that extirpative surgery and radiation had reached their limit of efficiency and that we must follow other paths of research. It is our fervent prayer that such lines of research will prove fruitful. In the meantime, properly utilized supervoltage therapy will increase our percentages of salvage, if not cures. It is my personal conviction that cesium 137 has its own unique advantages as well as most of the advantages of cobalt 60 or the multimillion volt assemblies.

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1. Brucer, M.: An Automatic Controlled Pattern Cesium 137 Teletherapy Machine, Am. J. Roentgenol, 75:49-55 (Jan.) 1956.
2. Paterson, Ralston: The Treatment of Malignant Disease by Radium and X-Rays: Being a Practice of Radiotherapy, Baltimore, The Williams and Wilkins Company, 1948, p. 165.

740 Magnolia Avenue.

These cases were presented at the Second Scientific Assembly of the Association's Annual Meeting, May 10-13. The protocols may be found on pages 977-982 of the May issue of The Journal.

Diagnostic Clinics: Diagnosis of Cases

Acute Diagnostic Problem

A right rectus incision was made and the abdomen opened. The small intestine in the upper part of the abdomen showed considerable redness with marked dilatation. The transverse colon was greatly dilated. Exploration revealed rupture of a posterior duodenal ulcer into the lesser peritoneal cavity. Free pus was flowing from an opening in the gastrohepatic omentum. This opening was enlarged, the pus evacuated and the ulcer demonstrated. It appeared that the rupture of the posterior duodenal ulcer had occurred perhaps three days previously, on Thursday, when the patient complained of spitting up more bile, and at 9:00 Saturday night the rupture through the gastrohepatic omentum had occurred flooding the abdomen with purulent material. The ulcer was closed by placing a piece of omentum over it. A gastrostomy was performed with a Foley catheter. The gigantic coils of small intestine were deflated with an intestinal deflater and the abdomen washed out with 2½ quarts of penicillin solution, 1,000,000 units to each 500 cc. The abdomen was closed with interrupted through and through wire sutures one centimeter apart with 5-0 black silk to the skin edges.

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Heart and Lung Disease

In summary, this case was that of a 20 year old white male with a heart murmur from infancy and severe kyphoscoliosis developing at age six to eight. Despite moderate physical restrictions, he got along fairly well until his last year of life when repeated cardiac failure developed which finally became intractable. At postmortem, there were found severe compression of both lungs with long-standing atelectasis of the left and, to some extent, right lower lobes, widespread pulmonary edema, massive cardiomegaly, equally right and left, and a probable functionally insignificant high ventricular septal defect and persistent ductus arteriosus.

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Clinicopathological Conference

University of Mississippi Medical Center

Dr. Lois M. Mosey, Assistant Professor of Obstetrics and Gynecology, University of Mississippi Medical Center, Jackson, Miss.

Dr. Joel G. Brunson, Professor and Chairman, Department of Pathology, University of Mississippi Medical Center, Jackson, Miss.

Dr. Lois M. Mosey: I understand the usual procedure at this exercise is to review with you the protocol. It is an extremely short protocol but, I thought, well written. We have an adequate amount of information to make at least some deductions.

This patient, a 28 year old gravida 8, para 3, stillborn 1, abortion 4, was admitted to the emergency room of the University of Mississippi Medical Center on March 9, 1961, at 11:45 a.m. in a moribund state. The only available history was provided by her husband and a short note from her local physician. Seventy-two hours prior to admission of the patient chills with high fever developed. She was admitted to a local hospital and 24 hours later delivered a stillborn infant at five and one-half months' gestation. She had a history of frequent urinary tract infections, especially with her last three pregnancies. She had had some dysuria and frequency for about one week prior to the onset of the present illness.

About 12 hours after the delivery of the stillbirth, which was 36 hours prior to admission here, she went into shock and apparently had not been out of shock since that time.

The note from the local physician supplied the following data. Laboratory work on the day of admission: Urinalysis gave negative results. That is interesting if true; it probably should be viewed with a large grain of salt. The red blood cell count was 3,680,000, hemoglobin estimation 10 Gm. and white blood cell count 3,800 with 58 per cent polymorphonuclears with 24 stab forms and 42 per cent lymphocytes. After the episode of shock had developed on March 9, the hemoglobin was 10 Gm. The medications the patient had received prior to admission were Levophed drip at a concentration not stated, 40 mg. of cortisone intramuscularly, 200 mg. of Depo-Heparin, and Aramine. No other medication was mentioned; I wonder if she received any antibiotics.

On physical examination on admission she had signs of shock, with no blood pressure, no pulse and cold, clammy and cyanotic extremities. The temperature was 97.2 F. This is a fairly important point, I think, in the diagnosis of what has happened in this patient. She had a gasping type of respiration and a rapid heart rate of over 180. The lungs were clear. The abdominal examination was not remarkable. The fundus was palpable three fingerbreadths above the symphysis. On pelvic examination, tenderness must not have been a large part of that examination as it was not mentioned. There were no abnormal findings for a postpartum patient at this period of time. On insertion of a Foley catheter the absence of urine was confirmed.

The hematocrit reading was 35 and the white blood cell count now 45,000. Cultures were taken from the blood and from the cervix, and would have been from the urine if there had been any, I am sure. The admitting diagnosis was gram-negative shock secondary to genitourinary infection with a rather extensive list of differential diagnoses. Intravenous therapy was begun with Solu-Cortef, Chloromycetin and aqueous penicil-

lin, but the rapidly downhill course continued and the patient died one and one-half hours after admission.

Somebody said to me as we were coming down here, "They did not really give us much information in this particular protocol, did they?" Actually, this particular protocol could have been lifted from at least three or four different articles that I have read recently as being a case history of a condition called bacteremic shock, endotoxic shock, or gram-negative shock. This is what I think this patient had, and I will attempt to rule out some of the other conditions in a short period of time. This is a syndrome that has been interesting to obstetricians for not nearly as long as it apparently has been to internists. Probably the reason is that we had a convenient wastebasket diagnosis for many, many years by which we disposed of all sorts of cases. We said the patients were in obstetrical shock, and by definition this meant they were in shock without losing any blood. They died in "obstetrical shock," and we did not make the diagnosis. I think that since about 1956 this particular diagnosis has been entertained much more frequently on obstetrics and gynecology services.

In 1956, Studdiford and Douglas[1] from Bellevue Hospital in New York reported a series of cases of endotoxic shock following septic abortion. Pathologic study of these cases showed classic examples of bacteria, never in the blood stream but rather in the uterus; their toxic products were presumably absorbed from the endometrium into the open blood vessels that existed at the time of abortion. Based on that series these authors made a number of recommendations which have been followed. One was that the patients should be treated with massive doses of antibiotics and their uteri should be emptied of all necrotic infected debris as soon as they are seen. Since that time, reports of a number of series of obstetrical cases with endotoxic shock have been published. Adams and Pritchard,[2] in perhaps the most stimulating discussion of this subject in the obstetrical literature, reported a series from Dallas. A review[3] of maternal mortality caused by gram-negative shock from Shreveport in Louisiana has been published and many isolated cases reported. As cases have been garnered, criteria for the diagnosis of bacteremic shock have been established. These are based on the case examples collected in large series.

First among the criteria that Adams and Pritchard[2] established for making this diagnosis was that an infection must be present in either, generally speaking, the genital tract or the genitourinary tract. In their series of 15 cases, the infection was primarily in the genitourinary tract in nine, and in the patients with genitourinary infection and subsequent bacteremic shock the genitourinary infection occurred in conjunction with delivery or shortly thereafter. It was an extremely unusual finding, in their experience, for bacteremic shock to develop very late in the postpartum state. Hypotension must be present; there must be oliguria, and anuria of course is an extension of oliguria. Helpful in the making of this diagnosis is the frequency of classic case histories. Usually the patient has first a chill and fever, and the fever in most of the reported cases has been in the range of 103 to 104 and 105 F. We do not have this information in the case under discussion today, since the patient had chills and fever and her previous hospital admission at another institution. She was said to have chills and "high" fever. Then subsequently, the ominous forewarning or clinical sign of impending shock tends to be a rapid defervescence to levels below normal. At the time the patient came in, her temperature was 97.2 F. Adams and Pritchard[2] stated that they had seen patients with temperature as low as 93 F. immediately preceding the development of hypotension. Diminished urinary output is a constant phenomenon associated with this condition as is a rapid weak pulse.

Why could not this patient have something else? I notice in the differential diagnosis entertained at the time of admission, pulmonary embolism was considered. Pulmonary embolism might conceivably give this same kind of picture. As a matter of fact, when we are presented with a pathologic finding in this case, we may very well find there was diffuse pulmonary embolization. Clinical evidence suggests that a state of hypercoagulability exists at the same time as the bacteremic shock, and not infrequently small vessels in the lung are plugged by fibrin thrombi and a picture of diffuse pulmonary embolism may be seen. For acute blood loss, there is no evidence. The hemoglobin estimation had not changed in the time the patient was under observation if we can believe the laboratory report that we were given. She had no obvious external blood loss, and apparently there was little evidence for internal bleeding. We would be happier to rule this out completely. I wish someone had put a needle in either the peritoneal cavity or the cul-de-sac so that we could be cer-

tain the uterus had not ruptured. Again, for endometritis there is no evidence.

Another condition, however, which is not gram-negative shock but shock secondary to a severe septicemia, is occasionally seen, not as frequently now as it was in the days of Semmelweis, and that is an infection of the uterus postpartum with a hemolytic streptococcus. Patients with this infection, with no premonitory signs except occasionally abdominal pain, can go into profound change simulating the shock of acute blood loss or a state suggesting acute abdominal emergency. The period of time in which the acute picture developed in our case would not be inconsistent with such a diagnosis. The white blood cell count of 3,800 is of no particular help to us here although, again, this is more in line with gram-negative shock, since there is usually leukopenia to begin with and subsequently blood counts up to 50,000. This condition is not unlike that of our present patient; we have no really good evidence either for or against a fulminating postpartum Escherichia coli septicemia.

The only consideration that leads me finally to say that I am certain that we are really dealing with gram-negative shock, or at least bacterial shock secondary to genitourinary infection most probably gram-negative, is that the patient's prior history of (1) chills and fever, (2) previous pyelitis with pregnancy, (3) a stillborn child as a consequence of acute febrile illness, and (4) dysuria and frequency is overwhelmingly in favor of pyelonephritis of pregnancy, which is the background for endotoxic shock. I would not seriously consider any other diagnosis except to point out that I cannot rule out an acute fulminating septicemia due to a hemolytic streptococcus.

Therapy for this condition has varied from place to place. Some investigators think that pressor agents should be avoided if at all possible. The patient should be treated with massive doses of both bactericidal and bacteriostatic antibiotics and with sizable doses of cortisone and perhaps with blood replacement if it is needed. The consensus among those who have studied this problem is that one usually has to use pressor agents. One starts off with relatively mild pressors and works up to Levophed if needed. The amount of Levophed that must be added to the bottle to maintain the blood pressure provides prognostic information. Obviously, the more concentrated the solution, the more ominous the prognosis. In general, I think, the feeling is that one treats this sort of situation with pressor drips and with intravenous cortisone although scientific evidence for the use of cortisone is very, very poor. Measurements have been made of the circulating corticoids, and in most cases of bacteremic shock they are high normal, or elevated. Perhaps, despite the absolute level they are not high enough for the needs of the patient. Maybe they need to be elevated even higher, but certainly there is no element of adrenal failure involved in cases that have been carefully studied with this in mind.

In any case, cortisone, because it may do some good and it cannot possibly do any harm, and antibiotics in massive doses are used. Since the organisms with which we are most likely to be concerned are gram-negative, Chloromycetin and streptomycin and the various tetracyclines are the drugs that have been recommended. Some physicians are arbitrarily starting off with just a little smidgen of kanamycin, but why I am not sure, except that it is the newest and might help. Obviously, this is a very serious disease. The best therapy is to realize that it can happen following pyelonephritis in pregnancy, which is not a benign disease for pregnant women and would be a very serious problem for this if for no other reason. Pyelonephritis in pregnancy should be treated vigorously and for a prolonged period.

I would guess the kind of pathology we are to see today is the most severe variety of renal damage associated with this type of disease process and that is bilateral cortical necrosis. In general, I believe this has been associated, experimentally at least, with the generalized Shwartzman reaction. Endotoxic shock clinically is not too unlike the experimental model since pregnant humans as pregnant rabbits seem more susceptible to this phenomenon following a dose of endotoxin. There will probably be some congestion of other organs and even possibly small petechial hemorrhages of the myocardium. We may have evidence of thrombi in vessels in the lungs. I hope that we have a positive postmortem blood culture.

DR. JOEL G. BRUNSON: In regard to your comments about therapy, I think it might be wise to emphasize that in gram-negative bacteremia with shock, although about 80 per cent of patients will show an initial favorable response to vasopressor agents, the over-all survival rate does not greatly exceed that of those patients who are un-

treated with such drugs. I think what we do is to get into a vicious cycle of giving a little bit, and if a little bit helps we give much more until one reaches the stage in which vasodilatation, and not vasoconstriction, occurs.

We believe this patient had lesions attributable to gram-negative endotoxin, although we do not have bacteriologic evidence of endotoxin-producing bacteria in the blood. The cultures from the uterine cavity at the time of autopsy grew Esch. coli, although the blood cultures were sterile both pre and post mortem in this patient. I do not consider this to be an unusual situation. The only findings of importance were limited to the patient's kidneys, as you have suspected.

Gross inspection of the kidneys (fig. 1) revealed an extreme degree of paleness of the cortices. The pale or ischemic areas appeared opaque and were fairly well demarcated by hemorrhagic zones about them. This was correctly interpreted by the prosector as cortical necrosis of the kidneys. Microscopically (fig. 2), these areas of necrosis appeared about the same age, and showed varied degrees of surrounding inflammatory reaction. The patient also had evidence of a chronic active pyelonephritis, but the outstanding change was one of acute ischemic necrosis of the cortices. Many of the glomeruli (fig. 3) contained pink hyaline material which occluded the glomerular capillaries and, in some areas, was present also in the afferent arterioles and in the walls of the interlobular arteries. In some areas, portions of the necrotic tissue had already undergone calcification. We used to assume that this process took many months, and perhaps it does under other conditions, but in experimental cortical necrosis of the kidneys calcification develops rapidly, as early as 48 hours after production of the necrosis.



Fig. 1.—Gross photograph of kidney showing pale, ischemic areas of cortical necrosis accentuated by darker zones of hemorrhage.

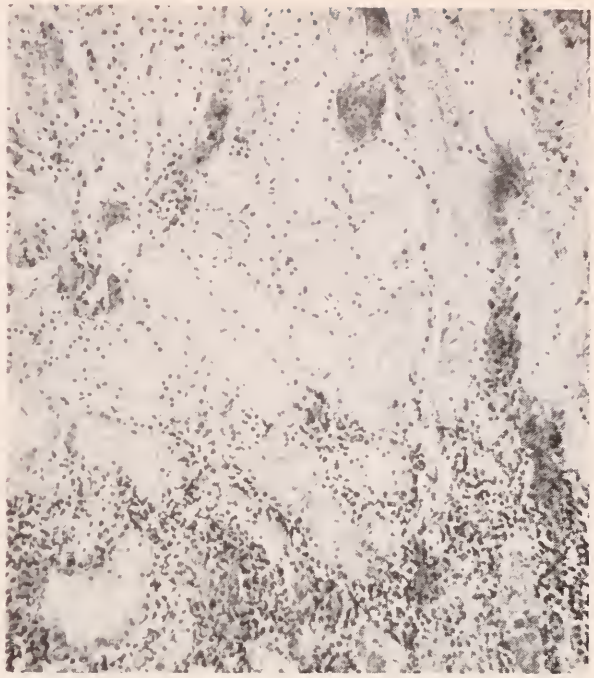


Fig. 2.—Photomicrograph of an area of necrosis from the kidney shown in figure 1. Note coagulated tubular cytoplasm, pyknotic nuclei, and surrounding inflammatory zone.

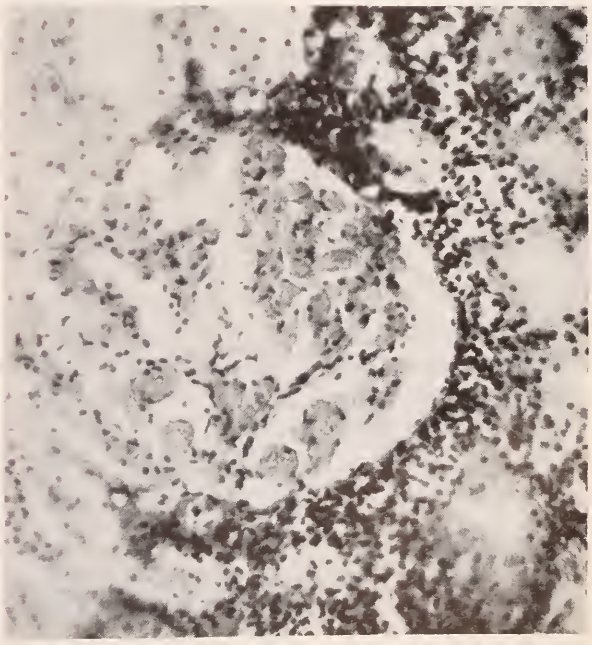


Fig. 3.—Photomicrograph of renal glomerulus which shows the capillaries to be occluded by dense, hyaline material.

Scattered hyaline thrombi were observed in the pulmonary capillaries, but not in sufficient numbers to change the clinical course in this pa-

tient or to alter it one way or the other. They were present also in the splenic sinusoids, but there was no evidence of splenic infarction. In the sinusoids of the right adrenal gland, similar-appearing thrombi were observed, in association with multiple areas of hemorrhage and necrosis. This finding was limited to the right adrenal gland and I doubt that it was of any clinical importance insofar as over-all adrenal function was concerned.

The evolution of this lesion has been, as Dr. Mosey has intimated, a subject of much interest in many circles for many years. It is related, I believe, to what is called the generalized Shwartzman phenomenon. With the rabbit as an experimental animal, this phenomenon usually requires two intravenous injections of gram-negative endotoxin, spaced 18 to 96 hours apart. When the lesion develops in rabbits, it is similar to that just described in this patient. About four hours after the second injection of endotoxin, the renal glomerular capillaries begin to show accumulations of hyaline thrombi. Over the next four to 12 hours, this condition increases in severity, produces complete occlusion of the capillaries and arterioles, and results in renal cortical necrosis. There is considerable evidence to indicate that the hyaline material which occludes the vessels is derived from fibrinogen and may represent a partially polymerized form of this material. In this sense it is somewhat different from the usual fibrin clot and has different tinctorial properties.

There are a number of experimental procedures that can bring about the occurrence of this lesion in rabbits. One method is to pretreat them with cortisone and then give them endotoxin, and another method is to utilize abdominal radiation in conjunction with endotoxin administration. Other factors which may be operative are the injection of large polymers which combine with fibrinogen and precipitate in various capillary beds. There is a distinct correlation between plasma fibrinogen levels and the development of this lesion in the kidney. Twenty-four hours after the initial injection of endotoxin, the plasma fibrinogen level in rabbits is almost doubled. If the normal fibrinogen value in the rabbit is about 200 to 300 mg. per hundred cubic centimeters, it will rise to 500 or 600 mg. within 24 hours after endotoxin is given. Then if a second injection of endotoxin is administered, there is a precipitous decline in plasma fibrinogen levels.

If the kidneys are sampled during this one to eight hour interval, there is gradual increase in severity of the renal lesion, culminating in bilateral cortical necrosis. If the animal survives for 72 hours or longer, fibrinogen levels gradually rise to values above normal levels, and remain there as long as the animal survives. It appears, then, that fibrinogen is involved in this reaction, and it can be shown by chemical determinations and electrophoretic pattern that this is a peculiar form of fibrinogen which is precipitated from heparinized plasma when stored at 4 C. for two hours (the heparin precipitable fibrinogen fraction). It is also of interest that the administration of large amounts of heparin will prevent this fall in fibrinogen, and with the prevention of fall there is prevention of cortical necrosis. This takes fairly large amounts of heparin, and I doubt that the amount that this patient received would have been sufficient to prove beneficial.

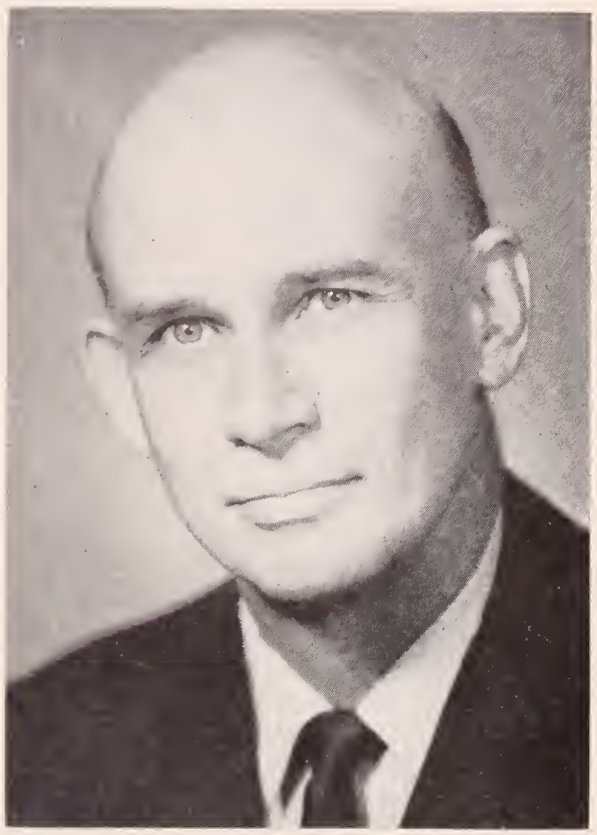
I mentioned that the reaction could be produced by abdominal radiation and endotoxin. This is somewhat dose-dependent, but with doses of 1,800 r, plasma fibrinogen levels may rise to over 1,000 mg. per hundred cubic centimeters. If at the height of the rise an injection of endotoxin is given, there is the same precipitous decline in fibrinogen as noted with two injections of endotoxin, and the development of cortical necrosis.

As long ago as 1933, Apitz demonstrated that pregnancy in some manner predisposes the rabbit to development of this condition. He showed that a single intravenous injection of endotoxin in pregnant rabbits results in renal cortical necrosis. The exact mechanism by which this occurs is not clear. Thus, if one can transpose the results of these and other studies to our present case, it would seem that this patient fits into an ideal position for this renal lesion to develop.

In summary, then, this appears to be a case in which delivery of a stillborn infant was followed by the development of gram-negative endotoxin shock and production of bilateral renal cortical necrosis.

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Robert Earl Zellner, M.D.,
Eighty-Second President

A native Floridian, Dr. Robert Earl Zellner of Orlando accedes to the presidency of the Florida Medical Association for the ensuing year. Born in Lakeland on March 2, 1915, Dr. Zellner received his elementary and high school education in the local schools and his academic training at the University of Florida, where he was awarded the Bachelor of Science degree in 1936. For his professional training he attended Rush Medical College at the University of Chicago, receiving the degree of Doctor of Medicine in 1940. He then served an internship at Grady Memorial Hospital in Atlanta, followed by a residency from 1942 to 1944 at Orange Memorial Hospital in Orlando.

For 15 years Dr. Zellner has engaged in the practice of general surgery in Orlando. He is an attending surgeon at Orange Memorial Hospital and is on the courtesy staff of Holiday Hospital in Orlando, Winter Park Hospital in Winter Park and West Orange Memorial Hospital in Winter Garden.

In the Orange County Medical Society Dr. Zellner has held the chairmanship of the insurance, public relations, medicolegal and numerous other committees and has been a member of the board of censors and the executive council. He served as president in 1958.

His service in the Florida Medical Association includes membership on the Insurance Committee from 1951 to 1953 and chairmanship of the Medical Economics Committee from 1953 to 1957. He was a member of the Committee of Seventeen from 1956 to 1960 and chairman in 1959.

Dr. Zellner served as a lieutenant in the Medical Corps of the United States Naval Reserve from January 1944 to August 1956. He was assigned to duty with the United States Marine Corps Amphibian Tractors for nine months at Dunedin and two years at Camp Pendleton in California.

Locally, Dr. Zellner is a member of the Rotary Club of Orlando, the University Club of Orlando, the Country Club of Orlando and the First Methodist Church.

Dr. Zellner and Mrs. Zellner, the former Jean Brown of Lakeland, have three children, Judy, a 1961 Emory University graduate, now teaching, Cynthia, a sophomore at Emory, and Robert, Jr., who enters college in the fall for premedical training.



Skin Disinfection

A surgical antiseptic should be bactericidal against a wide range of organisms but particularly against staphylococci, streptococci, and coliform bacilli. It should be rapid in its action and nontoxic even after repeated application to the same patient. No single substance at present fills all these requirements.

Much of the information concerning surgical antiseptics is fallacious as the tests used to elucidate their effect are often crude, open to misinterpretation, or fraught with unsuspected errors. For instance, the quaternary ammonium compounds were originally thought to be highly bactericidal on the skin when tested by taking wet cultures of the skin before and after their application. The failure of these organisms to grow from the cultures taken after application was, however, due to carryover of the substance onto the culture medium; this was exerting a bacteriostatic effect in vitro rather than a bactericidal effect in vivo.

Of the tests in common use, the estimate of wound infections before and after application of a particular substance is obviously crude and has so many uncontrolled factors as to be almost valueless. Attempts to culture the bacteria on the skin before and after application of the substance under investigation have the drawback already mentioned; in addition, the bacteria obtained by this method are almost all transients and these are very vulnerable to any treatment or even none. Implanting known organisms on the skin and then attempting to obtain them after surgical cleaning is a more accurate method of using this test, as the effect of the antiseptic can be assessed not only qualitatively but also to a certain extent quantitatively. It has the same objections, however, as its crude predecessors, and in addition the organisms implanted are not natural inhabitants of the skin and probably would disappear if left alone. These tests tell little concerning the effect of antiseptics on the deeper layers of skin organisms, but they are capable of being carried out on a fairly large scale and with many different investigators, using no uncommon equipment.

In vitro tests neglect the effect of organic materials, soap residues, and skin secretions on the bactericidal effectiveness of antiseptics and tell nothing of their toxicity, nor do estimates of the physical properties, fat solubility and surface tension of the antiseptics correlate in any way with bactericidal power. Price's serial basin handwashing test is probably the most accurate, providing not only qualitative information but also estimating the number of bacteria left on and in the skin following each step during the test, and the rate at which the count is diminished by the antiseptic. It is cumbersome, time-consuming, and expensive both in space and laboratory facilities, but accurate so far as is known.

As well as testing the bactericidal effect of an antiseptic by itself against skin flora, its effect in combination with other substances should be known. There may be a marked and surprising difference between the two. Small residues of soap on the skin reduce the bactericidal effect of the quaternary ammonium compounds of which Zephiran is the best known. Alcohol affects hexachlorophene in the same way, and the use of either of these combinations leads to false confidence in effectiveness of the method of surgical preparation.

Tests of toxicity of surgical antiseptics are few and far between. Only one such test is described, the Infection-Prevention-Toxicity-Test of Spalding and Bondi using mice. How accurate it is is not known nor how valuable, as the development of sensitivity to an antiseptic is of more con-

cern than the absorption of a toxic dose, and it is the latter which this test measures. The toxicity of an effective antiseptic may, however, be modified without materially affecting bactericidal power. A 7 per cent solution of tincture of iodine produces many burns, a 2 per cent solution only a few, and a 1 per cent solution very seldom any, unless used repeatedly on the same patient, but by exposing the skin to these weaker solutions for a longer time—30 seconds for the 2 per cent solution, and 3 minutes using two applications for the 1 per cent solution—the skin is well cleaned and by removing the iodine with alcohol the risk of sensitivity is diminished still more.

A skin antiseptic to be effective must not only destroy the superficial bacteria but must also get to those living in the deeper layers of the skin and the mouths of the sebaceous glands. The superficial transients are frequently pathogens and are implanted from whatever the skin has touched; they are only loosely held on the skin by dirt and grease and are easily removed by soap and water and scrubbing, though soap itself is not bactericidal. The resident flora is usually and principally composed of Staphylococcus albus, though in the presence of infected wounds, nasal carriers of pathogenic organisms, or heavy and frequent transient infestations, more pathogenic bacteria may become established. This resident group lives in the crevices and intercellular spaces of the desquamating superficial cells and can only with great difficulty and some damage be completely removed by scrubbing. In normal surgical circumstances the main purpose of an antiseptic is to destroy these bacteria. The antiseptic is placed in contact with them partly by removing the superficial layers of the skin during the preoperative shave and the initial soap and water scrub and partly by mechanical spreading during the repeated application of the antiseptic. Iodine, if ionized, is absorbed by the skin, unlike most of the antiseptics, and thus affects some bacteria protected from the usually purely surface application.

The length of time for which an antiseptic is effective is important, but once again information is scanty. The resident flora if considerably reduced and disturbed slowly regains its former numbers and composition. This may take two or three days. The deeper residents, however, which may be unaffected by the antiseptic appear on the surface of the skin after an hour or two. What effect the physiological state of the patient and the surgeon's activities have upon the rate of their appearance during the operation is not known. Sweat itself is sterile, but if profuse, helps to carry to the surface the deeper resident bacteria and spread them over it. A similar effect would seem to follow from excessive manipulation and traction of the skin.

In case of an infected wound or a known skin carrier of pathogenic bacteria, the wound may be isolated from the contaminated skin by the use of sterile nonporous, nonabsorbent adhesive plastic sheet through which the incision is made. The sheet applied to the skin following the usual surgical preparation prevents the spread of the deeper pathogenic bacteria unaffected by the surgical preparation into the wound area. The routine use of this material, however, introduces yet another complication to the operating room and may by itself lead to inefficient skin preparation if too great a reliance is placed upon it; if the sheet is applied improperly or perforated during the operation, organisms may enter the operative field. In addition, it provides no protection from the skin through which the wound is made. The ordinary skin towels provide little protection of the wound from the skin and by becoming wet and blood-soaked, they encourage bacterial growth close to the wound.

The patient only occasionally needs his skin cleaned surgically; the attendants need theirs cleaned all the time. The daily use of most of the surgical antiseptics is eventually harmful to the skin. There are, however, soaps for all skins, and hexachlorophene or 70 per cent alcohol seldom if ever produces sensitivity. Hexachlorophene, moreover, is suitable for continuous rather than occasional use for it has little effect on the resident flora in less than three daily applications.

The surgeon may thus easily be led to place false confidence in his method of cleaning his patient's skin. What may appear to be an effective method using a satisfactory antiseptic agent may actually rely for its apparent success entirely on nothing more than the mechanical removal of transient bacteria by scrubbing with soap and water. The many operations which have been performed without subsequent infection through relatively unprepared skin are perhaps more a credit to the habitual cleanliness of the patients than to the effectiveness of the surgeon's applications. The use of an effective bactericidal agent in conjunction with soap and water remains as necessary now as it was at the beginning of the antiseptic era. Nevertheless, with increasing knowl-

edge, the hunt for such an acceptable agent becomes more difficult.

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NICHOLAS R. GREVILLE, M.D.
GAINESVILLE

Cesium 137 Supervoltage Therapy

Radiologists continue to strive to improve equipment and methods of treatment for neoplastic diseases. Cobalt, cesium units, multimillion volt therapy units and betatron equipment are all part of the intensive efforts on the part of physicists, manufacturers of x-ray equipment and radiologists to provide better results in radiotherapy.

Some of the statements made in the article entitled "Cesium 137 Supervoltage Therapy" appearing in this issue of The Journal are at variance with those of other authors. The most apparent source of criticism would be the statement that the depth dose of cesium 137 is very close to cobalt 60 as conventionally used. The dose rate of cesium 137 is very low compared with the dose rate of cobalt 60. For this reason, it is common practice to reduce the distance from the source to the skin to 18 to 22 cm. in order to get an adequate exposure dose rate. This short distance results in a depth dose not greater than a 250-300 kv. roentgen therapy unit used at 50 cm.

For this reason, cesium 137 units are well suited to treatment of malignant lesions of the head and neck when they are relatively superficial. Cesium therapy units are used for treatment of malignant disease of the head and neck by the Anderson Hospital in Houston, Texas, and Duke University Hospital in Durham, N. C.

A statement by the author that there has been a sharp curtailment in the manufacture of roentgen ray generators because of cesium 137 and cobalt 60 is hardly justified by the statistics of the manufacturers of roentgen therapy apparatus.

Cesium 137 units are extremely valuable in the treatment of neoplastic diseases of the head and neck, but they are by no means comparable with cobalt 60 teleotherapy units or multimillion volt roentgen ray generators used at conventional treatment distances. As L. H. Garland, M.D., President of the American College of Radiology, has stated, it is doubtful whether teleotherapy has actually cured any more cases of neoplasm than the conventional 250-300 kv. roentgen ray equipment.

JOHN S. STEWART, M.D.
FORT MYERS

News

A Seminar in Pediatric Neurology and Neurosurgery has been scheduled for September 27-29 at the University of Florida College of Medicine in Gainesville.

Chief topics include convulsive disorders in children, infectious disease, brain tumors, and hydrocephalus and subdural hematoma. Visiting faculty for the Seminar includes Dr. Sidney Carter, Clinical Professor of Neurology and Chief, Division of Pediatric Neurology, Columbia Presbyterian Medical Center, and Dr. Donald D. Matson, Clinical Professor of Neurosurgery at Harvard Medical School.

The 46th Annual Tournament of the American Medical Golf Association is being held June 25 at the St. Andrews Country Club in Chicago. Special buses will be available for transportation of American Medical Association members.

Dr. Walter J. Baker of Foley has been honored by the people of his home county, Taylor, for more than 40 years of active practice there. Included in the festivities were a parade, formal ceremonies and a dinner.

Meetings scheduled in the state of Washington during the Seattle World's Fair which ends on October 21 include postgraduate courses at the University of Washington School of Medicine, the 73rd Annual Meeting of the Washington State





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Medical Association and many section meetings. A listing is available from the Association at 1309 Seventh Avenue, Suite 201-202, Seattle 1, Wash.

Dr. William A. Little, Assistant Professor of Obstetrics and Gynecology at the University of Florida College of Medicine, has been named a Markle Scholar in Medical Science.

Dr. Sanford Cobb of Miami has resigned as Associate Professor and Acting Chairman of the Department of Anesthesiology at the University of Miami School of Medicine to enter private practice at Anniston, Ala.

"Medicine in the Atomic Age" is the theme of the American Medical Association's 111th annual convention being held June 24-28 at McCormick Place in Chicago. The May 19 issue of the Journal of the American Medical Association has the complete scientific program; advance registration, hotel accommodations and luncheon reservation forms.

Dr. Mozart A. Lischkoff of Pensacola has been elected to membership in the Fifty Year Club of American Medicine.

Because of the added importance of the estimation of serum cholesterol and due to the wide variations in results in the measurement of serum cholesterol, the Standards Committee of the College of American Pathologists will characterize a best cholesterol standard for universal use and recommend an analytical procedure which may serve as a consistent point of reference. All laboratory directors and pathologists in the United States have been invited to participate. Inquiries may be addressed to Cholesterol Survey, College of American Pathologists, Prudential Plaza, Chicago 1, Ill.

The Florida Medical Association — Hillsborough County Medical Association exhibit at the 1962 Florida State Fair at Tampa attracted several thousand visitors. Featured were the two American Medical Association exhibits, "Transparent Woman," and "Life Begins." During the first week of the Fair, the Sabin trivalent oral poliovaccine was offered to eligible recipients who visited the exhibit.



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Deaths

Clark, Samuel Allen, Lakeland; born in Hephzibah, Ga., in 1877; Medical College of Georgia, Augusta, 1901; interned at University Hospital, Augusta; engaged in the general practice of medicine and obstetrics in Eatonton, Ga., from 1902 to 1925 and in Lakeland since 1925; served as a captain in the Army Medical Corps in World War I; was a past president of the Putnam County Medical Association in Georgia, the Polk County Medical Association; was a member of the American Medical Association and the Southern Medical Association; died April 5, aged 84, following a heart attack.

Mathers, Daniel Hutchinson, Sanford; born in White Springs on July 31, 1911; University of Maryland School of Medicine, 1940; entered the United States Navy in 1941, attended Flight Surgeons' School at Pensacola in 1943 and thereafter served as a flight surgeon until he received a medical retirement in May 1954; after retirement from the Navy practiced his specialty of ophthalmology and otolaryngology in Sanford;

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DR. JAMES ASA SHIELD
DR. GEORGE S. FULTZ, JR.

DR. WEIR M. TUCKER
DR. W. FREDERICK YOUNG

held membership in the Seminole County Medical Society, the American Medical Association and the Florida Society of Ophthalmology and Otolaryngology; died March 25, aged 50, following a coronary occlusion.

Watson, Herman Willis, Lakeland; born in Metter, Ga., on Feb. 12, 1889; Medical College of Georgia, Augusta, 1912; interned at Lamar Hospital, Augusta; after two years of postgraduate study in various cities throughout the United States, entered the private practice of medicine in Lakeland; served as a first lieutenant in the Army Medical Corps in World War I; completed extensive graduate study in Europe before resuming the practice of general surgery in Lakeland in 1920; founded the Watson Clinic of Lakeland; was a past president of the Polk County Medical Association and held membership in the American Medical Association, Southern Medical Association, Southeastern Surgical Congress and American College of Surgeons; served the Florida Medical Association as chairman of the Legislative Committee, chairman of the Council and as a member of the Editorial Board of The Journal; died March 31, aged 73.

Wilson, J. Frank, Jacksonville, born in Milledgeville, Ga., on Aug. 9, 1894; Medical College of Georgia, 1918, engaged later in postgraduate work in dermatology at Columbia University College of Physicians and Surgeons; served in the United States Navy in World War I; had practiced in Jacksonville since 1922, specializing in dermatology since 1928; was a life member of the Duval County Medical Society and a member of the American Medical Association, the Florida Society of Dermatology, the American Academy of Dermatology and Syphilology, and the Southeastern Dermatological Association; died Feb. 28, aged 67.

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Each yellow tablet contains:	Each orange tablet contains:
Methyl Testosterone ....2.5 mg.	Methyl Testosterone .....5 mg.
Thyroid Ext. (1/6 gr.) ....10 mg.	Thyroid Ext. (1/2 gr.) ....30 mg.
Glutamic Acid .....50 mg.	Glutamic Acid .....50 mg.
Thiamine HCl .....10 mg.	Thiamine HCl .....10 mg.

INDICATIONS: **Impotence in male.**

AVERAGE DOSE: One tablet three times daily.

AVAILABLE: Bottles of 100 and 500 at your pharmacy.

CAUTION: Not to be used when testosterone is contra-indicated. Federal law prohibits dispensing without prescription.

1. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

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Dosage: Hasamal: One or two tablets or capsules every 3 to 4 hours. **Hasacode:** One or two tablets every 3 or 4 hours; not more than 8 tablets should be taken in 24 hours. **Warning:** Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

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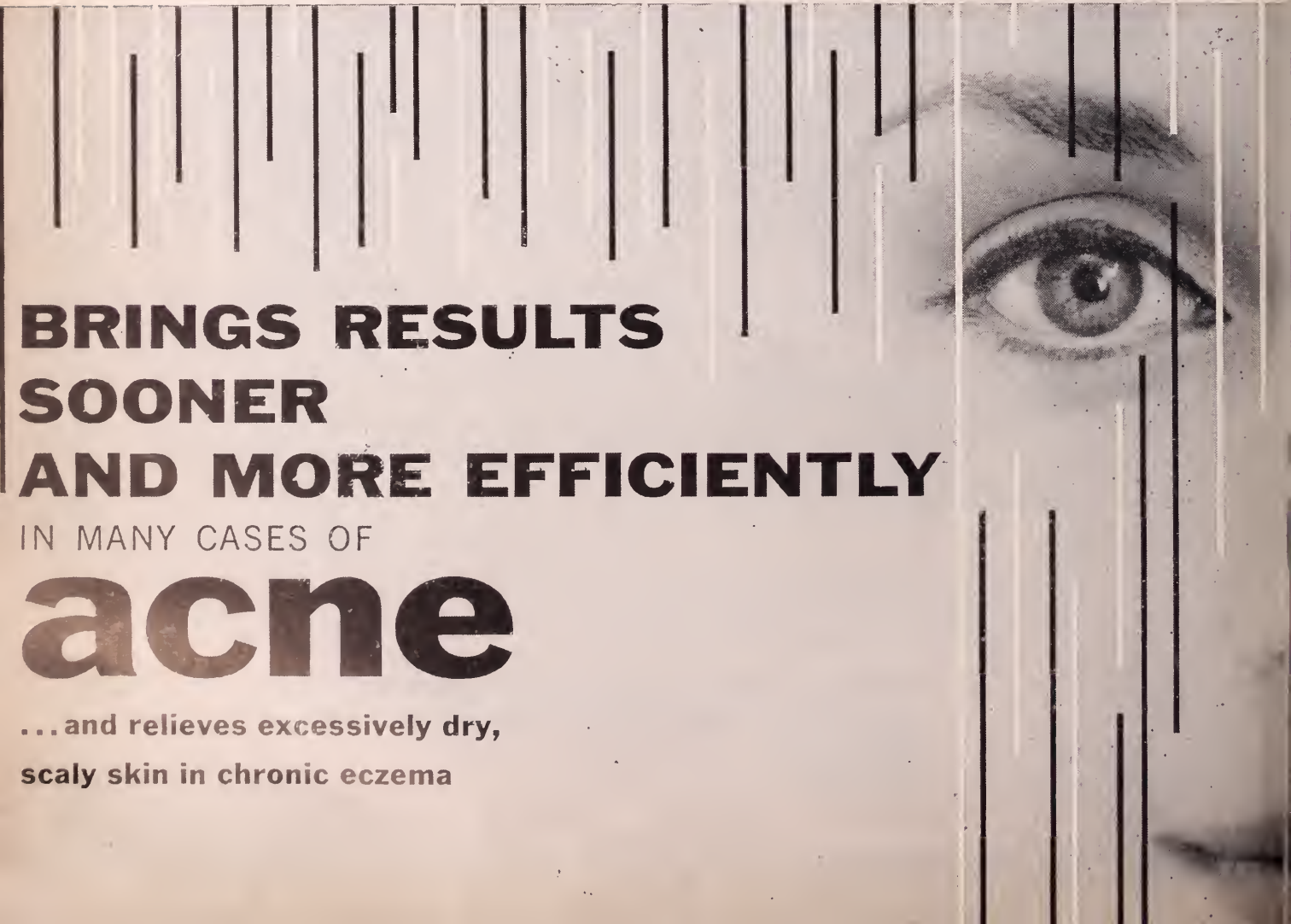
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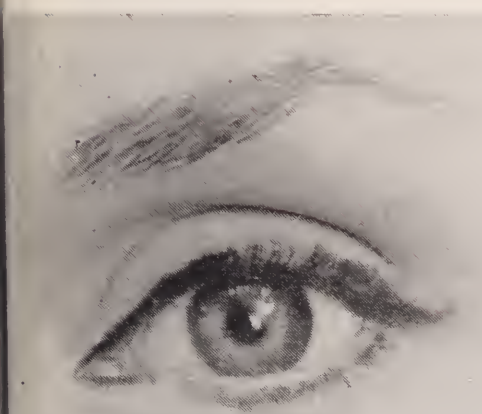
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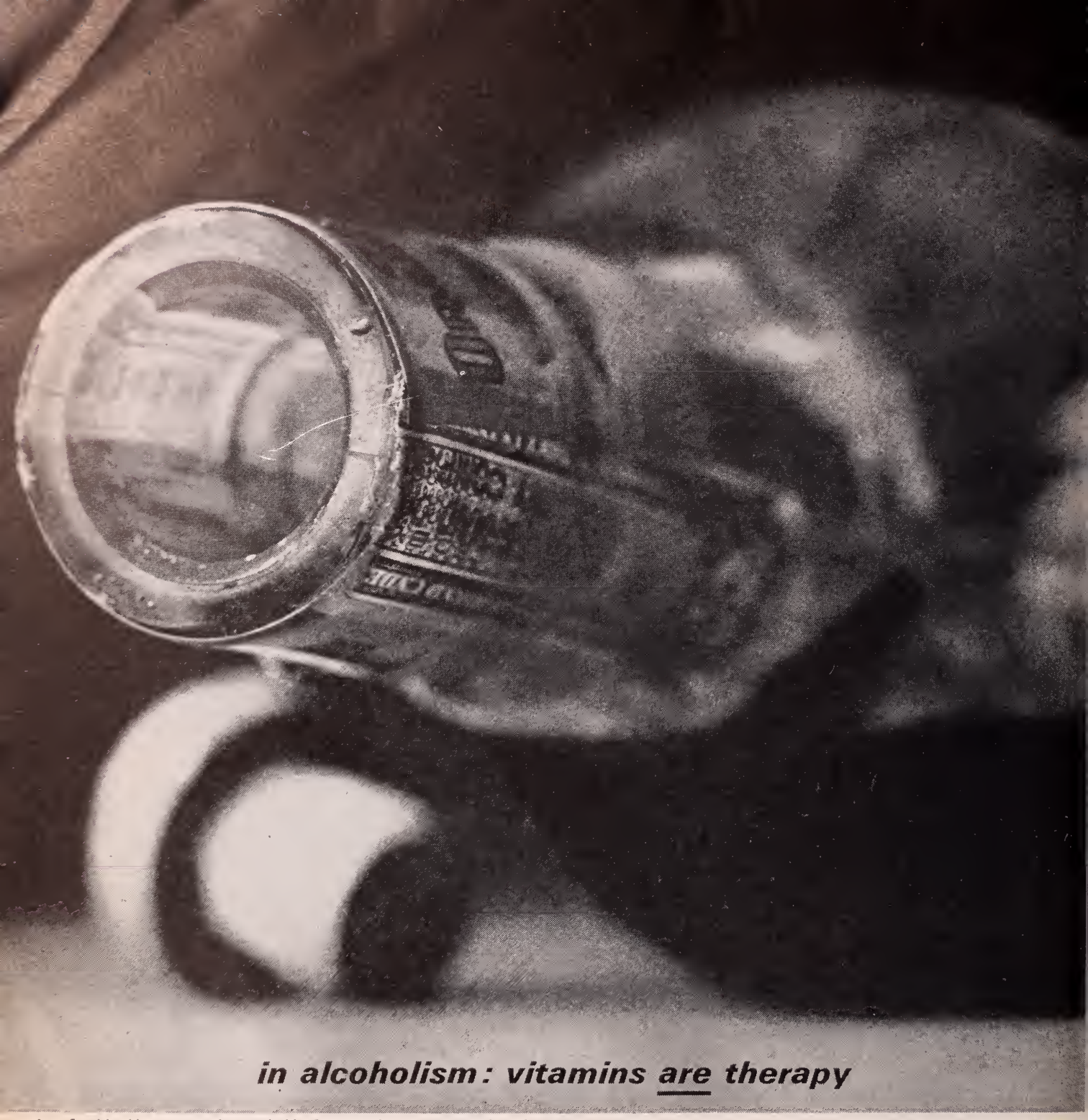
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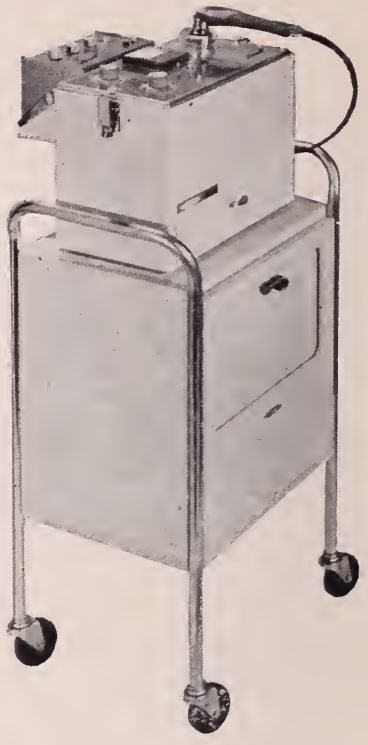
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Marriott Motor Hotel

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Sunday, June 17, 1962
King's Gateway Hotel and Inn

EAU CLAIRE, WISCONSIN
Wednesday, June 20, 1962
The Eau Claire Hotel

ATLANTA, GEORGIA
Wednesday, July 18, 1962
The Hotel Dinkler Plaza

SAN ANTONIO, TEXAS
Sunday, September 9, 1962
The Granada Hotel

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Sunday, September 9, 1962
The Stonewall-Jackson Hotel

TYLER, TEXAS
Wednesday, September 12, 1962
Carlton Hotel

KANSAS CITY, KANSAS
Friday, September 14, 1962
Battenfeld Auditorium

WOODSTOCK, VERMONT
Wednesday, September 19, 1962
The Woodstock Inn

NIAGARA FALLS, ONTARIO
Saturday, September 29, 1962
Sheraton-Brock Hotel

RAPID CITY, SOUTH DAKOTA
Saturday, October 6, 1962
Holiday Inn

FINDLAY, OHIO
Thursday, October 11, 1962
The Findlay Country Club

HONOLULU, HAWAII
Sunday, October 21, 1962
The Princess Kaiulani Hotel

NEWARK, NEW JERSEY
Sunday, October 28, 1962
Robert Treat Hotel

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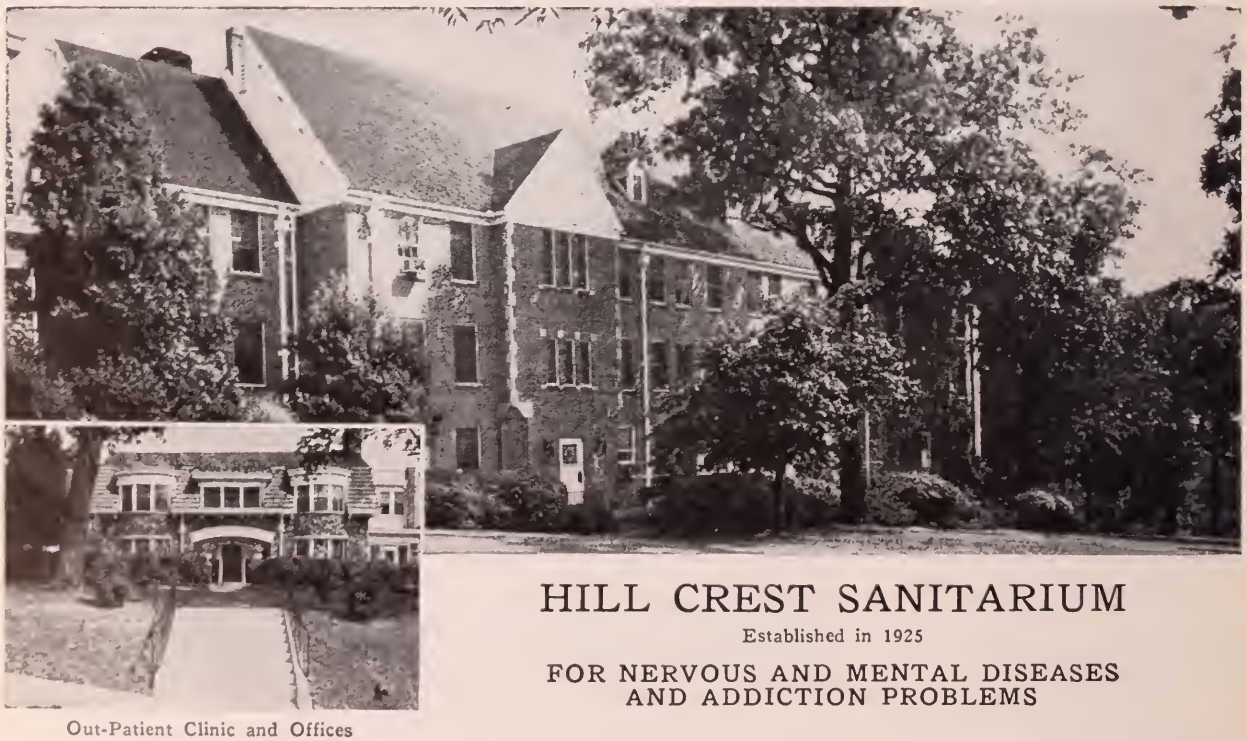
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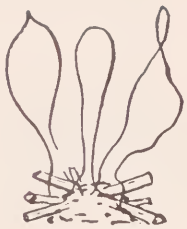
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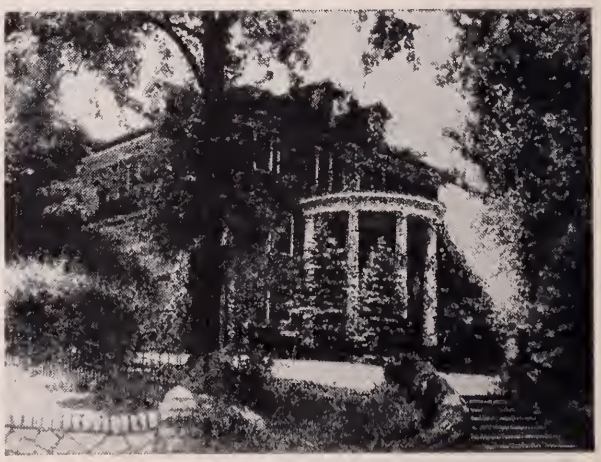
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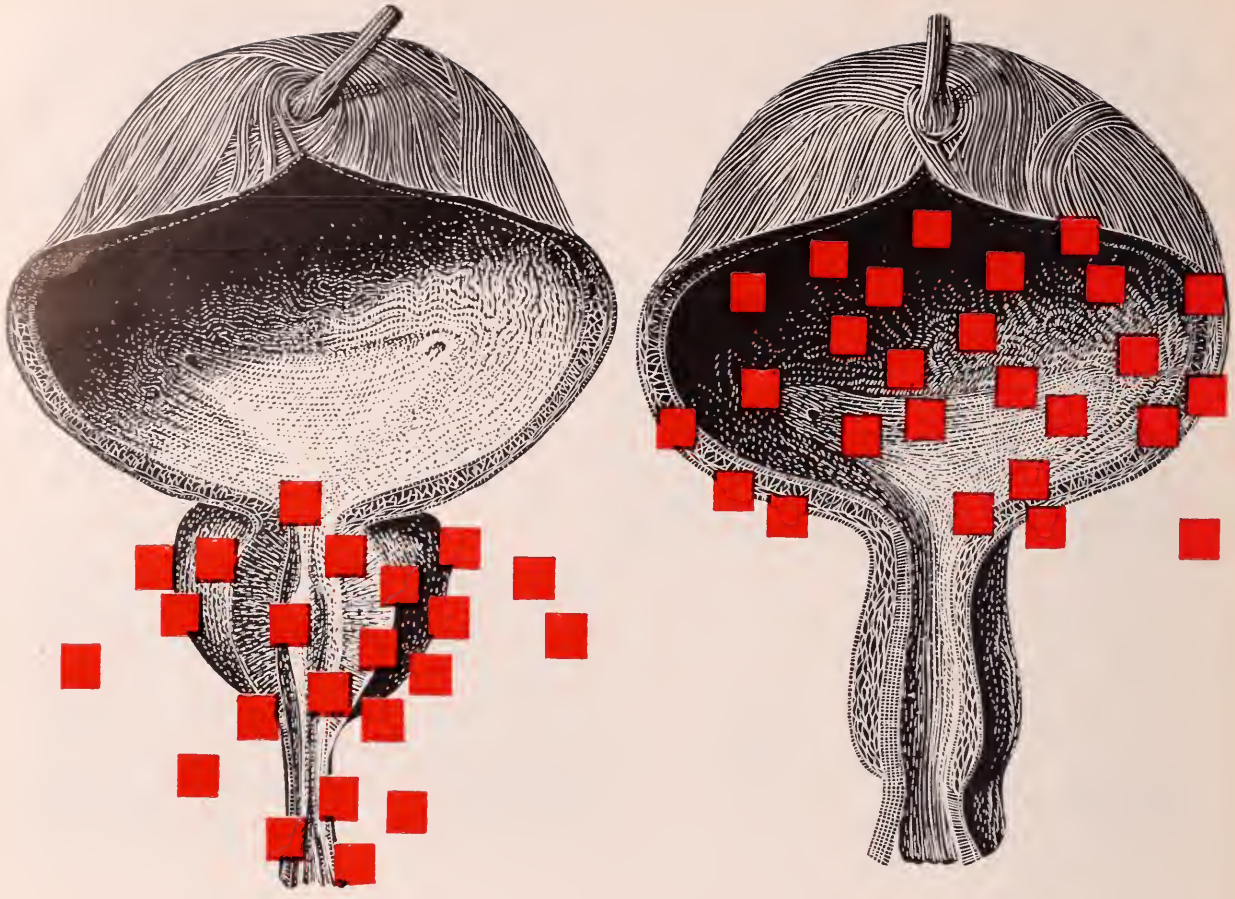
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*Gamble, C. J.: Am. Pract. & Digest Treat. *11*:852 (Oct.) 1960. See also Berberian, D. A., and Slighter, R. G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Olson, H. J.; Wolf, L.; Behne, D.; Ungerleider, J., and Tyler, E. T.: California Med. *94*:292 (May) 1961; Kaufman, S.A.: Obst. & Gynec. *15*:401 (Mar.) 1960; Warner, M.P.:J.Am. M. Women's A. *14*:412 (May) 1959.

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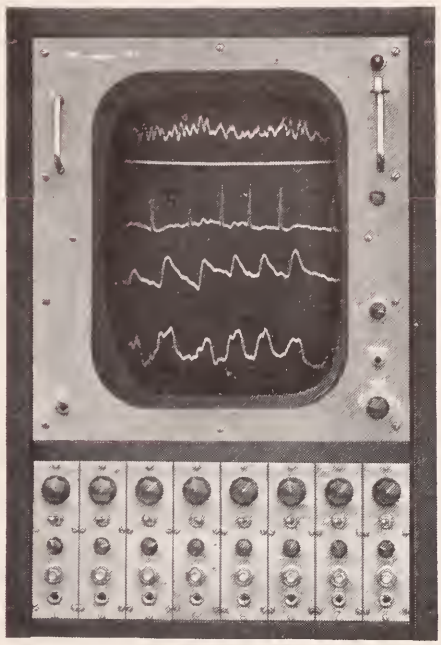
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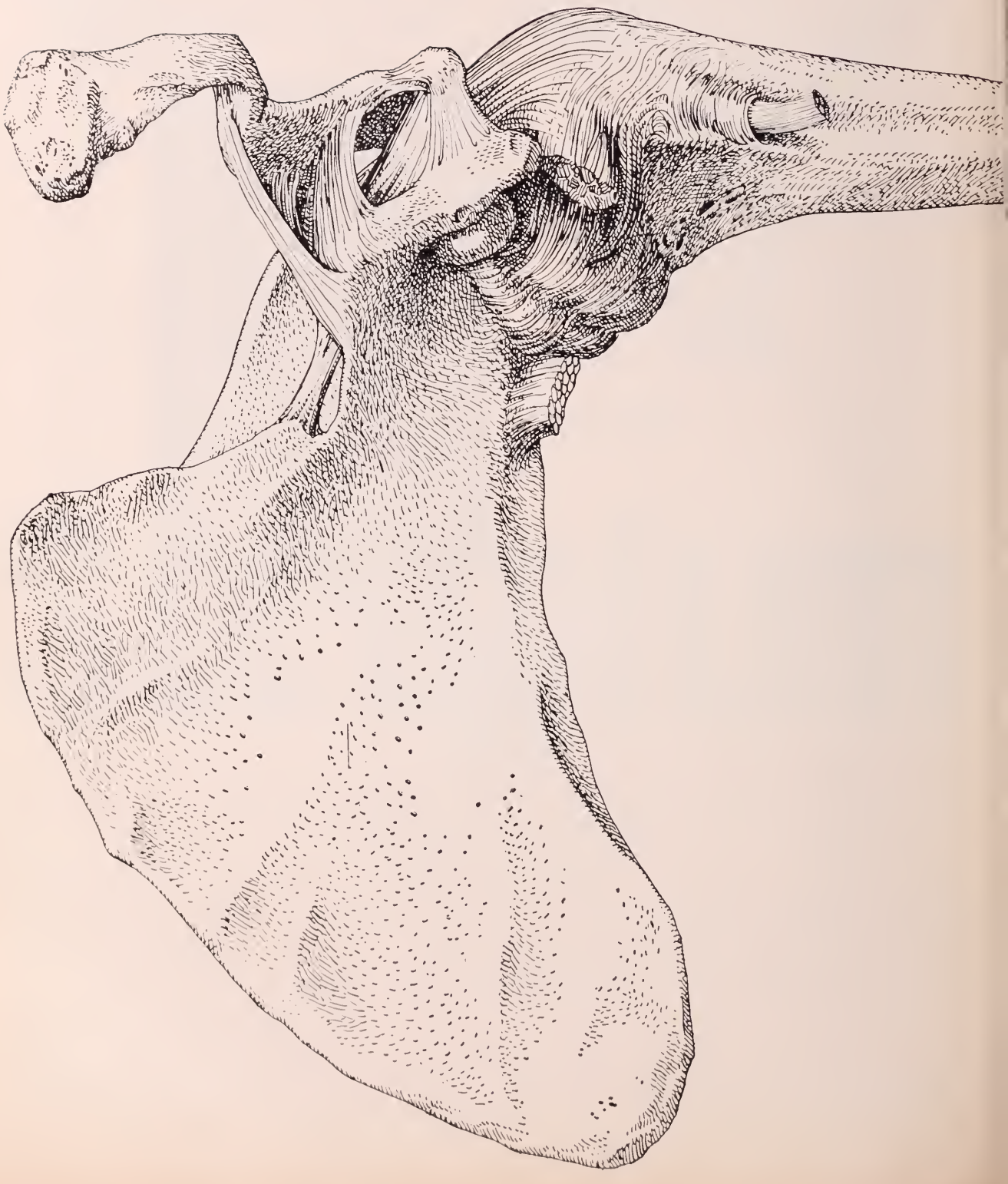




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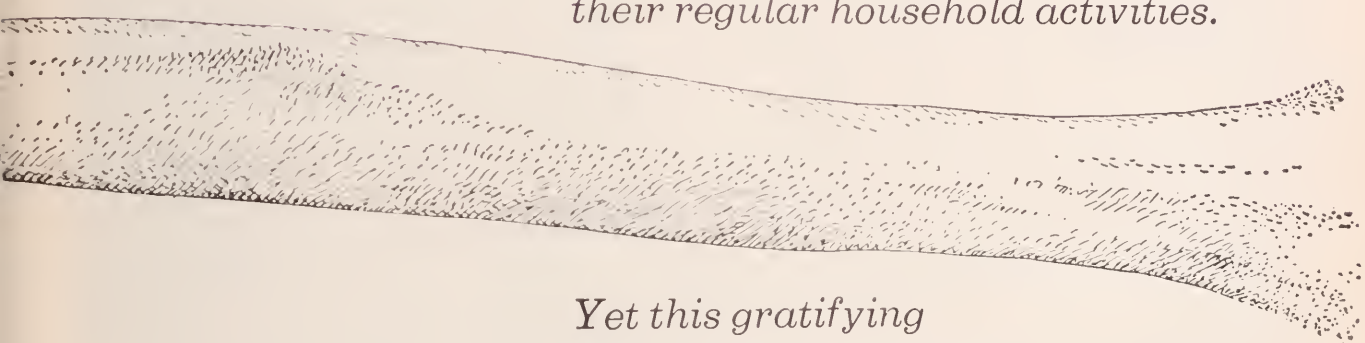
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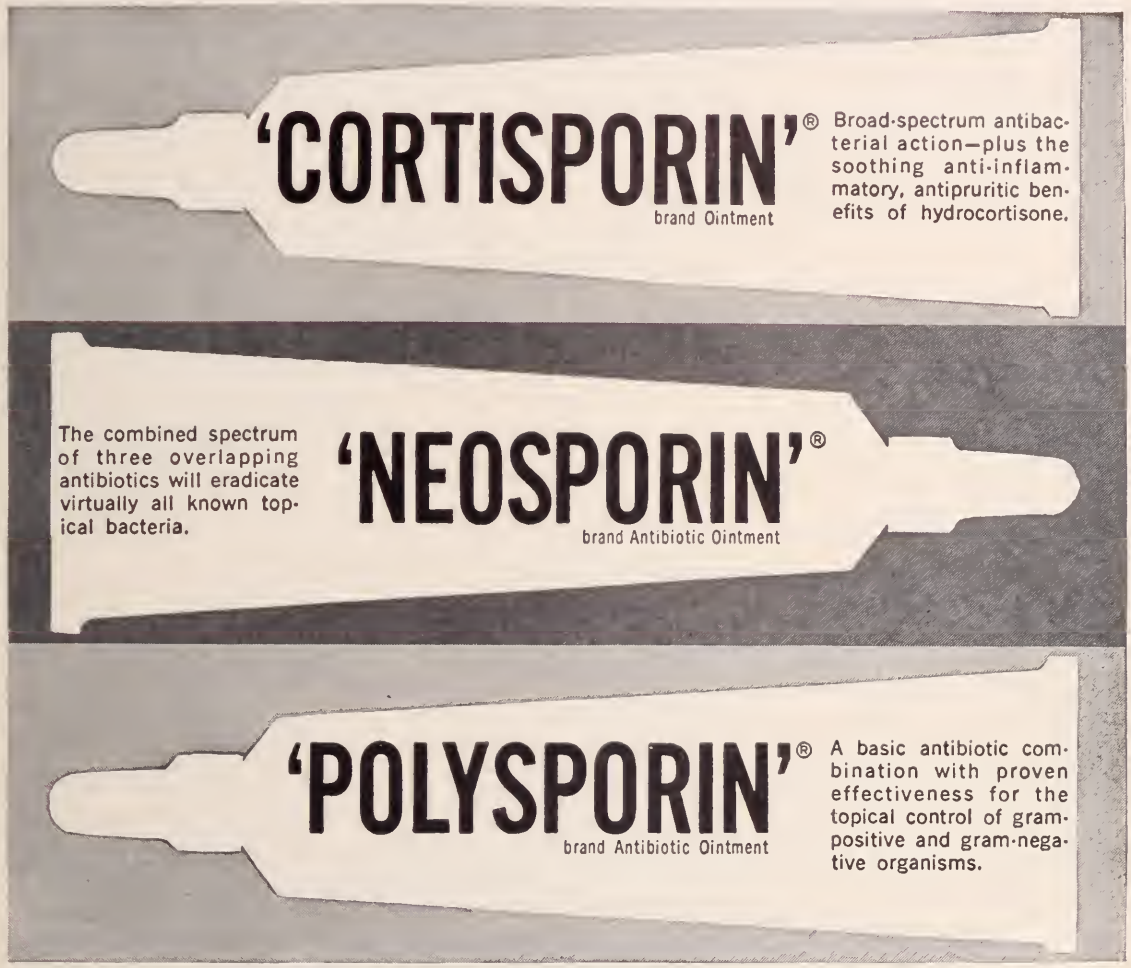
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Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

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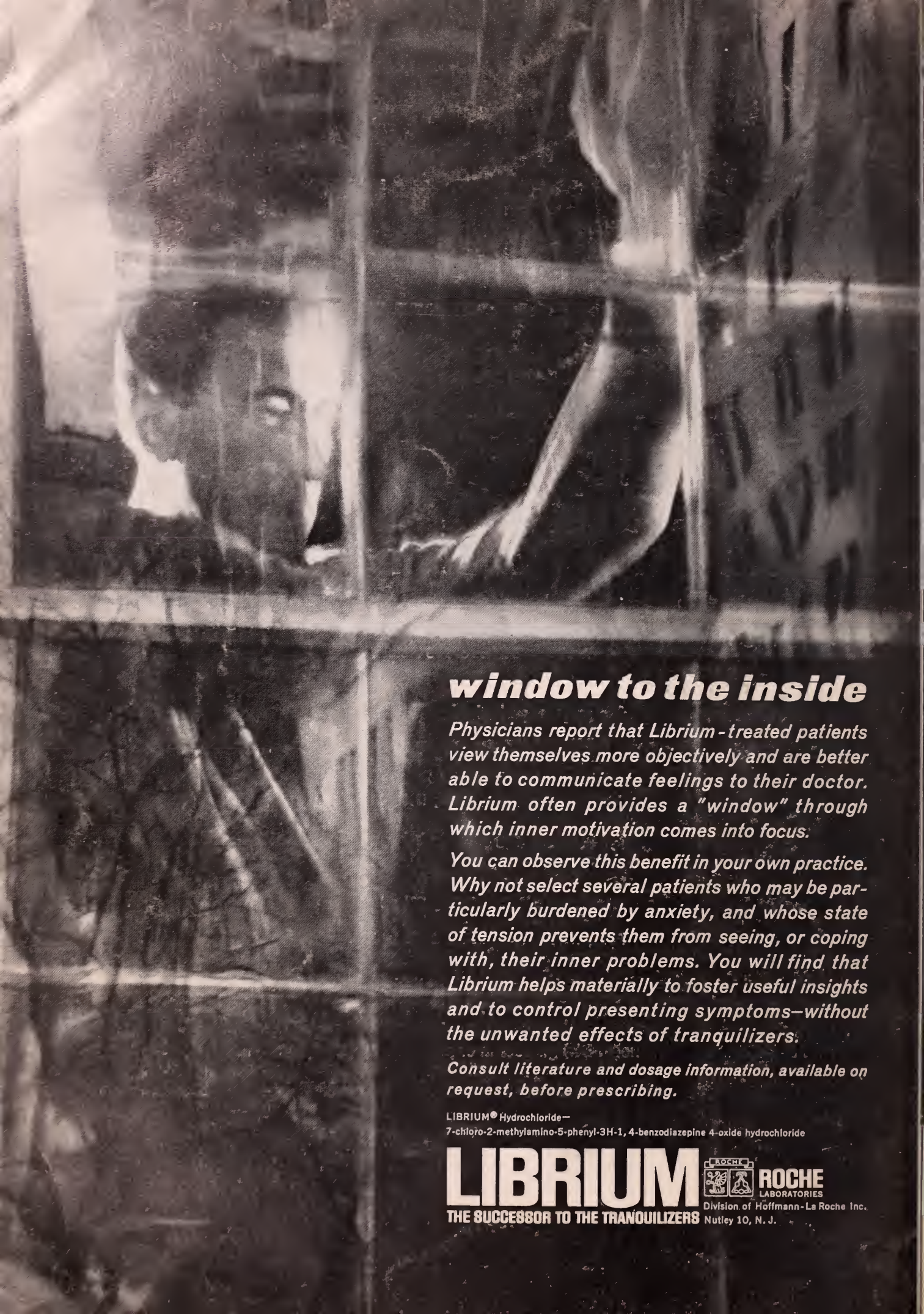
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